Partnering Toward a Healthier Future

2011 PROGRESS REPORT

Health Disparities in the Era of Reform Implementation

Compilation, analytics, and graphic design
by Avalere Health LLC

Kelly Brantley

Christine Harhaj

Caroline Pearson

www.avalerehealth.net

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Adventist HealthCare, based in Rockville, Maryland, is a non-profit network of healthcare providers that includes hospitals, home health agencies, rehabilitation centers, and other healthcare services that provide care throughout Maryland and New Jersey. In Maryland, the primary service area for Adventist HealthCare is the tri-county region of Frederick, Montgomery, and Prince George's Counties. In 2007, Adventist HealthCare launched the Center on Health Disparities with a mission to reduce and eliminate disparities in health status and healthcare access, treatment, quality, and outcomes throughout the diverse communities it serves.

The Center on Health Disparities (the Center) has three areas of focus: increased services for underserved populations, a research program to identify and promote best practices, and an education initiative to improve the ability of caregivers to provide quality care to all populations. The Center also hosts an annual conference bringing together community partners and promoting collaboration among those working to reduce disparities in the tri-county area. Each year, the Center releases a report highlighting issues related to health disparities and local efforts to improve health equity.

Dear Community Partners;

What an amazing journey we have been on! I cannot believe that five years have passed since Adventist HealthCare launched the Center on Health Disparities in 2007. We have come full circle in our travels.

In our first annual report on health disparities, we focused on our internal processes. We looked at how we could position Adventist HealthCare and the Center in our community and what practices we needed to change or enhance so that barriers to care within our walls could be eliminated. Together, with our Blue Ribbon Panel partners, we set goals for Adventist HealthCare and our local community in order to remove those walls completely.

Our second annual report highlighted our community partners' progress in the three areas we identified in 2007: 1) outreach and services for the needs of racial and ethnic minorities; 2) coordinated research into the underlying causes of health disparities; and 3) promoting culturally and linguistically competent care and funding mechanisms to foster the exchange of best practices.

In 2009, our report focused on the Center on Health Disparities' progress towards achieving cultural competence within all Adventist HealthCare entities, as well as how we were able to assist our community partners towards achieving this goal.

Last year we took the lens outside of the healthcare system. We studied and engaged in a powerful conversation on the social determinants on health. We saw how minorities and vulnerable populations are oppressed by social issues that have a direct impact on the health of individuals and communities, including socioeconomic status, education level, and environment.

In 2010 we also heard presentations from innovative programs such as The Harlem Children Zone and Place Matters. These initiatives are bringing non-traditional partners together to join forces with the healthcare industry in order to improve structural and social conditions. The goal of these programs is to nurture communities so that individuals can thrive where they live, work, learn, and play.

This year, we decided to take a step back and reexamine the progress the Center and our partners have achieved over the last five years. We also considered national healthcare reform legislation as it relates to eliminating health disparities and achieving equity: what can we do to make sure that the reasons reform was so desperately needed stay in the forefront of our policy makers' minds? We must ensure that the goals of reform—equal access to care, provider diversity, cultural competence, increased preventive care, affordability, and improved social determinants that influence health—impact all of our neighbors.

And who is our neighbor? In the Christian tradition, the well-known parable of the Good Samaritan describes a neighbor as one "who shows mercy" to another, with the admonition to "go and do likewise."

It is through the implementation of quality health programs, expanding access to care, and cultivating cultural competence, that we as health care providers, executives, policy makers, insurers, educators, and public health professionals demonstrate God's care.

Thank you for sharing in this journey with us as together we continue to grow.

Marcos Pesquera
Executive Director
Center on Health Disparities at Adventist HealthCare

Introduction

The ACA has created a strong impetus to improve health equity across all populations nationwide. The next steps are up to us.

THE CENTER ON HEALTH DISPARITIES' 2011 PROGRESS REPORT OFFERS AN UPDATE ON HEALTH disparities affecting communities in the tri-county region of Maryland that surrounds Washington, DC, a look at how health reform changes incentives to reduce health disparities, and new details on the Center's activities since the first annual report was released in 2007.

The first chapter of this report details demographic trends and assesses health disparities across a range of issues within three broad health topics—maternal and infant health, heart disease and stroke, and cancer—that align with the Centers for Disease Control and Prevention's Healthy People 2010 and 2020 goals. A primary purpose of this initiative is to achieve health equity, eliminate disparities, and improve the health of all groups. Similarly, over the last several years, Maryland has made significant progress in eliminating health disparities among various racial and ethnic groups. Though mortality rates for a number of health conditions and diseases have declined and more people are engaging in preventive care, racial and ethnic minorities in the area are still disproportionately affected by poor health outcomes compared to non-minority populations.

The report's second chapter offers an overview of the Affordable Care Act of 2010 (ACA)[1] provisions that will improve health equity by promoting coverage and quality of care for all underserved populations. This report categorizes provisions that address health disparities into four groups:

- The ACA expands access to insurance coverage.
- The ACA expands access to care.
- The ACA encourages quality measures and adherence to guidelines.
- The ACA promotes appropriate care.

The final chapter reflects back on the Center's inaugural report in 2007. In that report, we identified a specific set of initiatives that would bring us closer to the elimination of health disparities across all communities. Here, we highlight the activities the Center has undertaken to achieve the goals set forth by these three recommendations:

- Expand outreach and services to meet the needs of racial and ethnic minorities.
- Pursue coordinated research on the underlying causes of health disparities, the efficacy of various health initiatives, and the appropriate knowledge diffusion strategies for local communities and caregivers.
- Promote culturally and linguistically competent care and funding mechanisms to foster the exchange of best practices.

Through its partnership with Adventist HealthCare and numerous other community entities, the Center on Health Disparities has made great strides in addressing health disparities in Frederick, Montgomery, and Prince George's Counties. As the ACA is implemented over the coming years, there will be additional opportunities—as well as funding—to address health disparities in a more systematic way. The ACA has created a strong impetus to improve health equity across all populations nationwide. The next steps are up to us.

Data Methodology

This report incorporates descriptive findings from national, state, and county-level databases on the racial and ethnic makeup of the population, the prevalence of disease across these groups, and the rates of receiving appropriate treatment.

Nationally, we analyzed the U.S. Census Bureau's American Community Survey and Profiles of General Population and Housing Characteristics to produce a broad demographic overview by county, race, and ethnicity.

In Maryland, we produced descriptive tabulations based on data from the Maryland Behavioral Risk Factor Surveillance System, the Maryland Cancer Registry, the Maryland Vital Statistics Administration, the Maryland Health Care Commission, and the Maryland Department of Health and Mental Hygiene's (MDHMH) Office on Minority Health & Health Disparities.

In addition to these data sources, we have also summarized findings from various national and state-level reports on insurance coverage, disease conditions, and healthy behaviors released by the Agency for Healthcare Research and Quality (AHRQ), the Kaiser Family Foundation, and the MDHMH's Family Health Administration, Office of Chronic Disease Prevention.

Data Limitations

Despite extensive efforts to prepare comprehensive sets of health access and health status indicators across races and ethnicities at the county level, the following limitations persist:

- Much of the data, especially population-adjusted rates across race and ethnicity per county, were not available.
- Often, databases do not differentiate races in persons of Hispanic origin.
- Many databases also group Asian Americans and Pacific Islanders in an "other" category.
- Much of the data were obtained from different sources with various data collection and publication protocols.
- Large amounts of county data collected, processed, and checked could not be used due to privacy concerns related to a small number of observations.
- Self-reporting in surveys can generate under-reporting or over-reporting, yielding unreliable estimates.
- No tests were performed to determine the statistical significance of data.

Tables and Figures in this Report

Across tables and figures presented in the report, missing categories of race and ethnic groups at the county, state, or national levels may exist due to lack of classification or data availability. For example, Latinos may be grouped as part of a bi-racial category; disease and mortality rates from Asian Americans may not be reported.

Across populations and disease conditions, calculated percentage sums may not equate to 100 percent due to rounding.

Sample sizes for the tri-county area may be insufficient to generate conclusions at the state level.

Chapter One

OVER THE LAST 10 YEARS, THE TRI-COUNTY AREA OF MARYLAND—COMPRISED OF FREDERICK, Montgomery, and Prince George's Counties—has experienced a significant increase in the proportion of residents who belong to a racial or ethnic minority group. Much like the United States as a whole, the combined racial and ethnic minority population of both Maryland and these three counties has grown such that minority groups comprise almost half of the population.

As racial and ethnic populations become increasingly predominant, concerns regarding health disparities grow—persistent and well-documented data indicate that racial and ethnic minorities still lag behind non-minority populations in many health outcomes measures. These groups are less likely to receive preventive care to stay healthy and are more likely to suffer from serious illnesses, such as cancer and heart disease. Further exacerbating the problem is the fact that racial and ethnic minorities often have challenges accessing quality healthcare, either because they lack health insurance or because the communities in which they live are underserved by health professionals. As the proportion of racial and ethnic minority residents continues to grow, it will become even more important for the healthcare system to understand the unique characteristics of these populations in order to meet the health needs of the community as a whole. As a result, this report examines health status and outcomes among different racial and ethnic populations in Frederick, Montgomery, and Prince George's Counties across three health areas: maternal and infant health, heart disease and stroke, and cancer. These topics align with the Centers for Disease Control and Prevention's Healthy People 2010 and 2020 goals, and one of the main goals of this program is to achieve health equity, eliminate disparities, and improve the health of all groups.[2]

KEY TAKEAWAYS

- The proportion of Maryland residents of Hispanic ethnicity grew by nearly 50 percent from 2000 to 2010.
- Approximately 85 percent of Prince George's County's residents belong to a minority group, the highest percentage in the tri-county area; across the state, racial or ethnic minorities make up slightly over 45 percent of the population.
- Throughout the tri-county area, whites have the highest median household income, particularly in Montgomery County. Across the entire state, blacks are most likely to live in poverty.
- Hispanic residents in Maryland are more likely to be uninsured, while black residents tend to rely on Medicaid or other public insurance programs more than other racial groups.

Demographics of the Tri-County Area

Size and Growth of the Racial and Ethnic Minority Population in the Tri-County Area

Over the last 10 years, Maryland's overall population grew nearly six percent from 5.46 million residents in 2000 to 5.77 million residents in 2010. Much of this growth was driven by an influx of racial and ethnic minority populations, with the proportion of Hispanic residents increasing by almost 50 percent.

- Despite being the least populous county in the tri-county region, Frederick County experienced a larger overall population increase (about eight percent) than both Montgomery and Prince George's counties (around six and four percent, respectively). [Figure 1] While Frederick County's population growth between 2000 and 2010 was mainly attributable to a rise in Hispanic and black residents, the county is still predominantly white. [Figure 2]
- Of the three counties, Prince George's County has the largest proportion of minority residents, at 85.1 percent. [Figure 2] Approximately 63 percent of these minority residents are black. [Figure 2]
- The Hispanic population in the tri-county area grew by 50 percent over the last 10 years, representing the largest increase among all racial/ethnic groups. While Prince George's County has historically been a majority minority community, the 2010 Census indicates that, for the first time, less than half of Montgomery County residents are now non-Hispanic whites. [Figure 2]

FIGURE 1: Population of Maryland and Tri-County Area, by Race/Ethnicity, 2000 & 2010

	FREDERICK		MONTGOMERY		PRINCE GEORGE'S		ALL MARYLAND	
	2000	2010	2000	2010	2000	2010	2000	2010
White	172,000	181,600	519,300	478,800	194,800	128,900	3,356,500	3,158,000
Black	12,300	19,600	129,400	161,700	498,300	548,400	1,564,900	1,674,200
Asian	3,200	8,900	98,300	134,700	31,800	34,800	210,900	316,700
Hispanic or Latino	4,700	17,100	100,600	165,400	57,100	129,000	316,300	470,600
Total	**195,300**	**223,400**	**873,300**	**971,800**	**801,500**	**863,400**	**5,269,500**	**5,773,600**

Source: U.S. Census Bureau (2011). Profile of General Population and Housing Characteristics. http://planning.maryland.gov/msdc/

FIGURE 2: Share of Population of Maryland and Tri-County Area, by Race/Ethnicity, 2000 & 2010

	FREDERICK		MONTGOMERY		PRINCE GEORGE'S		ALL MARYLAND	
	2000	2010	2000	2010	2000	2010	2000	2010
White	88.1%	77.8%	59.5%	49.3%	24.3%	14.9%	63.4%	54.7%
Black	6.3%	8.4%	14.8%	16.6%	62.2%	63.5%	29.5%	29.0%
Asian	1.7%	3.8%	11.3%	13.9%	3.8%	4.0%	4.0%	5.5%
Hispanic or Latino	2.4%	7.3%	11.5%	17.0%	7.1%	14.9%	6.0%	8.2%
Proportion Belonging to Racial/Ethnic Minority	10.9%	22.2%	39.4%	50.7%	75.0%	85.1%	37.0%	45.3%

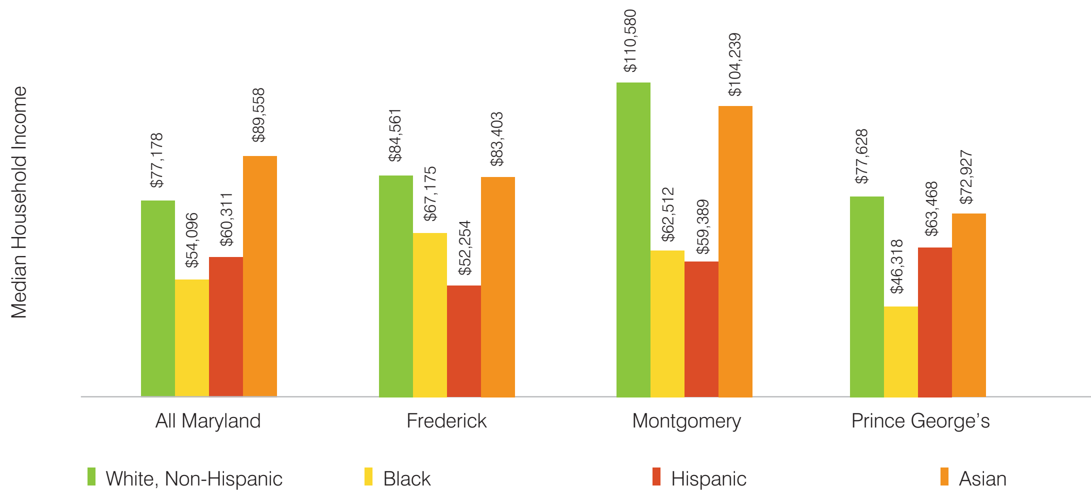
Source: U.S. Census Bureau (2011). Profile of General Population and Housing Characteristics. http://planning.maryland.gov/msdc/

Income and Poverty

Household income has a direct influence on a family's ability to pay for necessities, including health insurance and healthcare services. A wide body of research points to the fact that low-income individuals tend to experience worse health outcomes than wealthier individuals, clearly demonstrating that income disparities are tied to health disparities. Throughout the tri-county area, across racial and ethnic groups, non-Hispanic whites have the highest median household income, while blacks and Hispanics are more likely to live in poverty. [Figure 3, Figure 4] However, when looking at the state of Maryland as a whole, Asians have the highest median income. [Figure 3]

- The median household income in Maryland in 2009 was $61,193, compared to the U.S. median of $50,221.[3]
- White households in Montgomery County had the highest median household income ($110,580) in the tri-county area, while black households in Prince George's County had the lowest ($46,318). In Frederick and Montgomery Counties, however, Hispanics had lower median household incomes than whites, blacks, and Asians. [Figure 3]

FIGURE 3: **Median Household Income, Tri-County, Maryland, by Race, 2009**

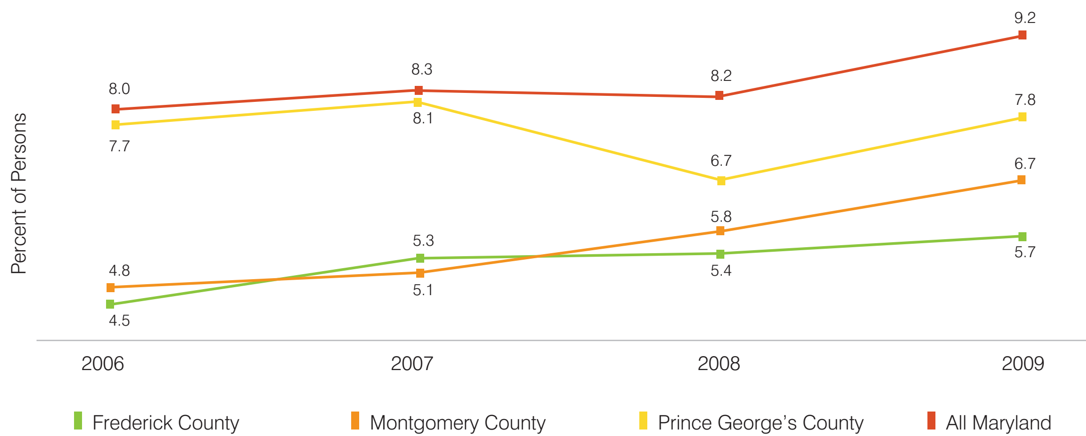


Source: U.S. Census Bureau. (2011). American Community Survey 1-Year Estimates.
http://www.census.gov/acs/www/09

- While Prince George's County still has the highest proportion of residents living in poverty, Montgomery County experienced the greatest increase in poverty, with nearly a 40 percent rise between 2006 and 2009. [Figure 4]
- In 2010, across all counties in Maryland, as well as within the tri-county area, more residents are living below the poverty level than in 2006. In 2006, eight percent of Maryland residents lived in poverty; by 2010, just over nine percent of people have income below the poverty line, representing a 15 percent increase. [Figure 4]

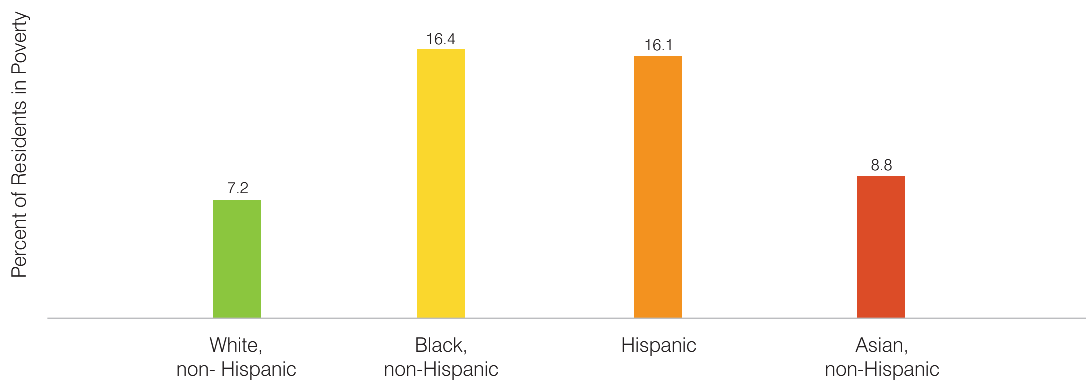
- In 2008, when the national recession first began, all residents of Prince George's County, which has a majority minority population, experienced a significant downturn in household income, while the household income of residents of Montgomery and Frederick Counties was more stable. [Figure 4]
- Across the state, nearly a quarter of black residents had incomes less than 100 percent of the federal poverty level (FPL) in 2010. Approximately 16 percent of both black and Hispanic residents were impoverished at this time, compared to seven percent of whites and nine percent of Asians. [Figure 5]

FIGURE 4: **Percent of Residents Living Below Poverty, Tri-County, Maryland, 2006-2009**



Source: U.S. Census Bureau. (2011). Small Area Income and Poverty Estimates. http://www.census.gov/did/www/saipe/index.html

FIGURE 5: **Poverty Rate by Race, Maryland, 2010**



*In 2010, 100% of poverty for a family of four was $22,350.

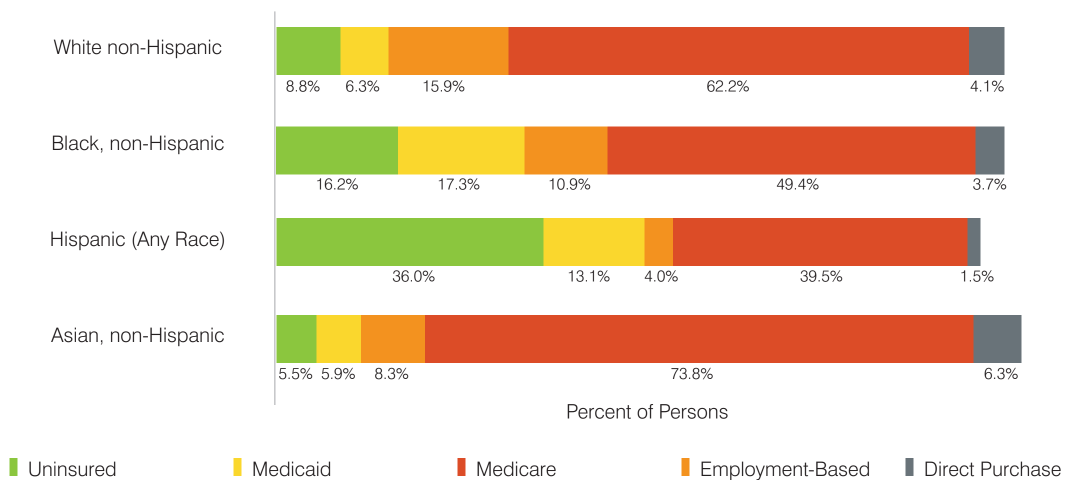
Source: U.S. Census Bureau. (2011). Current Population Survey. http://www.bls.gov/cps/

Health Insurance Coverage

AHRQ's 2010 National Healthcare Disparities Report defines access to healthcare as the efficient and timely use of personal health services to obtain the best health outcomes. The report states that racial and ethnic minority groups—as well as people with low incomes—have disproportionately high rates of uninsurance or coverage through public programs. Overall, minorities tend to have more limited access to healthcare services—and the care they do receive is often of poor quality—which results in a multitude of healthcare complications.[4]

- In 2010, Hispanics in Maryland were uninsured at more than twice the rate of blacks and more than four times the rate of whites. [Figure 6] Asians are most likely to have health insurance coverage through an employer-based plan than any other racial or ethnic group.
- Black individuals are more than two times as likely to be covered by Medicaid as whites across the state of Maryland. [Figure 6]

FIGURE 6: **Health Insurance Coverage of Non-Elderly by Race/Ethnicity, Maryland, 2010**



* Percents do not add to 100% due to military health insurance coverage

Source: Current Population Survey. (2010). Health Insurance Coverage of Non-Elderly. http://www.bls.gov/cps/#data

- According to the U.S. Census Bureau, approximately 12.9 percent of all Maryland residents under the age of 65 were uninsured. In the tri-county region, the highest rate of uninsurance (16.3 percent) was seen in Prince George's County; in contract, 10.5 percent of Frederick County residents were uninsured, while just over 12 percent of Montgomery County residents were uninsured.
- Across the state, Hispanic males are more likely (37 percent) not to have health insurance coverage than white, non-Hispanic men (10 percent) and black, non-Hispanic men (17 percent). The trend is similar among females in Maryland: Hispanic women are uninsured at a rate of 30 percent, while almost 8 percent of white, non-Hispanic women and 12 percent of black, non-Hispanic women are uninsured.
- In Frederick, Montgomery, and Prince George's Counties, men are more likely to be uninsured than women. Nineteen percent of males in Prince George's County do not have health insurance, while 13 percent of females in the county are not covered. In contrast, just under 12 percent of men and 9 percent of women in Frederick County are uninsured. In Montgomery County, rates of uninsurance among men and women stand at almost 14 and 11 percent, respectively.[5]

Maternal and Infant Health

Poor access to prenatal care and poor birth outcomes in Maryland's minority communities remain central issues of concern to health professionals. Nationally, the infant mortality rate among black infants is 13.3 deaths per 1,000 live births, which is more than double the rate among whites (5.6 deaths per 1,000 live births).[6] In general, Maryland's rates of infant mortality are similar to national averages: 13.6 black infants die per 1,000 live births, compared to 4.1 white infants. Across Maryland, both black and Hispanic expectant mothers are more likely to receive late or no prenatal care than white expectant mothers.

Birth Rates

In 2009, there were 77,974 live births in Maryland, up from 74,880 in 2005. In the tri-county area, there were nearly 17,000 live births among blacks and Hispanics, compared to just over 14,000 among whites. The birth rate for Hispanic mothers was the highest of the three groups across all three counties and for all of Maryland.[7]

- The birth rate for Hispanic mothers in the state grew by over 40 percent between 2005 and 2009. During this same time period, the birth rate among white mothers in Maryland decreased 11 percent and remained the same for black women.[8]
- In 2009, the birth rate among girls of all races between the ages of 15 and 19 in Maryland was 31.2. The adolescent Hispanic birth rate, however, was just over double that figure, at 66.4.[9]

KEY TAKEAWAYS

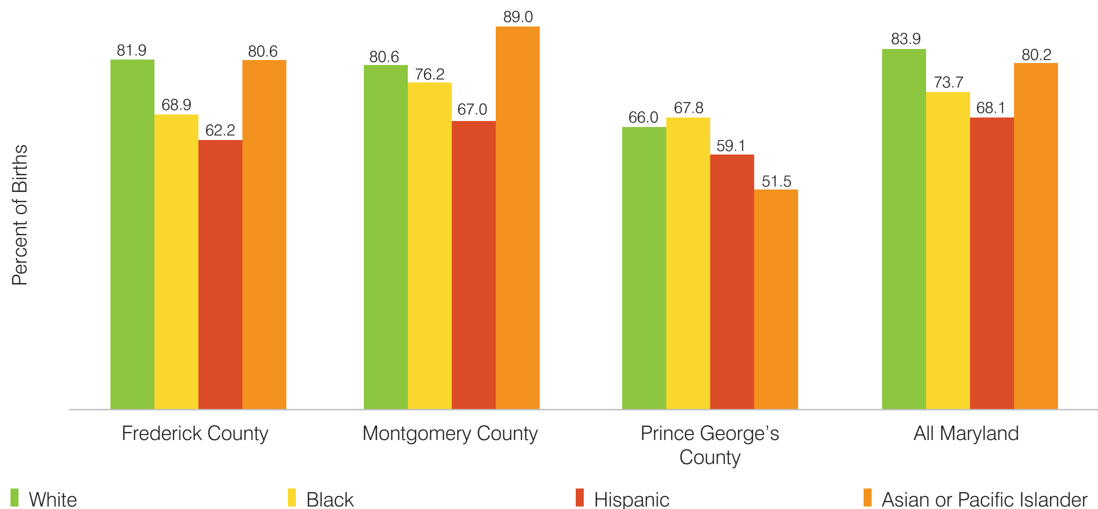
- Across Maryland, rates of prenatal care are going down and rates of low birth weight are going up, but infant mortality continues to decrease as medical advances make it possible to save more at-risk babies.
- Although infant mortality is generally decreasing, blacks continue to experience the highest rates of infant mortality in the state.
- Expectant Hispanic and black mothers in the tri-county region are more likely than white women to receive late or no prenatal care; black women are most likely to deliver low birth weight babies.
- The adolescent birth rate among Hispanics is approximately double the pregnancy rate of other adolescent populations across the state.

Receipt of Prenatal Care

The relationship between certain maternal behaviors and adverse pregnancy outcomes is well known; chief among these behaviors is the receipt of early and appropriate prenatal care. Ideally, prenatal care should begin in the first trimester of pregnancy, or, preferably, prior to conception. This is especially important for minority women, as they experience higher rates of infant mortality and are also more likely to deliver low birth weight babies.

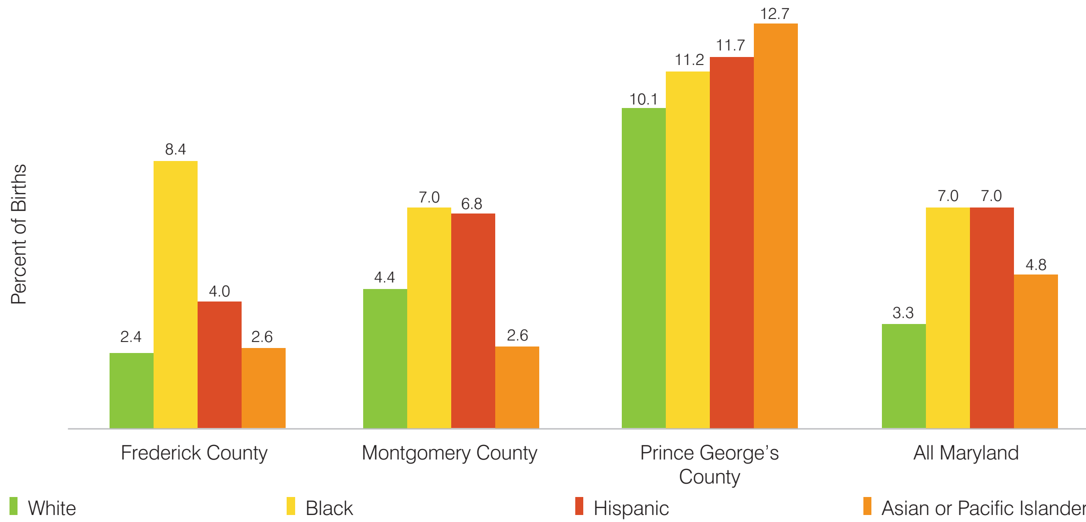
- Across racial and ethnic groups in Maryland, Asian women are the most likely to receive prenatal care during the first three months of pregnancy. However, while over 80 percent of Asian women in two counties of the tri-county area received prenatal care in their first trimester in 2009, this was not the case in Prince George's County, where only 51 percent of Asian women received prenatal care early in their pregnancies. [Figure 7]
- On average, black women in the tri-county area are most likely to receive late or no prenatal care. The highest rate among this racial group is seen in Prince George's County, where just over 11 percent of expectant black mothers did not get the pregnancy care they needed in 2009. [Figure 10] In comparison, just over two percent of white pregnant women in Frederick County received late or no prenatal care. [Figure 8]
- Over the last 10 years, the percent of pregnant women receiving late or no prenatal care has increased across the board in Maryland, indicating that rates of appropriate prenatal care are declining. [Figure 9]

FIGURE 7: **Percent of Births to Women Receiving Care in the First Trimester by Race/Ethnicity, Tri-County, Maryland, 2009**



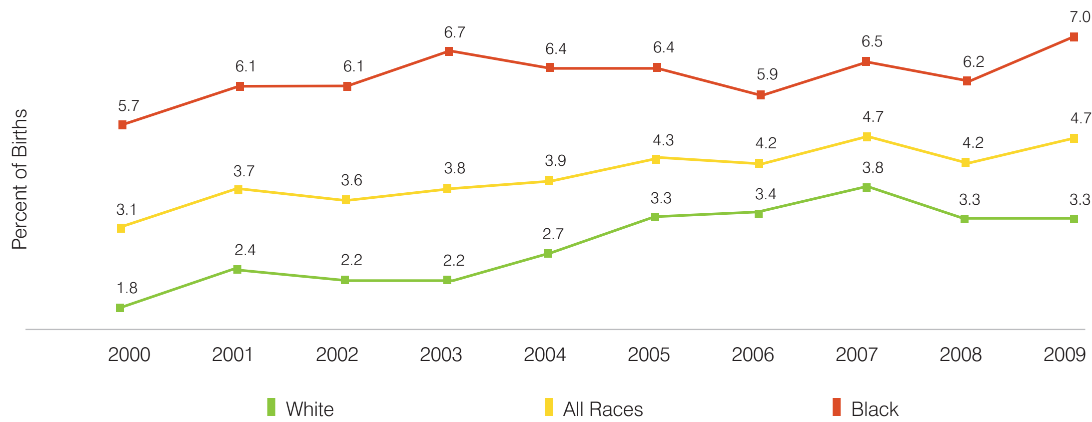
Source: Maryland Vital Statistics Administration. (2010). *Annual Report 2009*. http://vsa.maryland.gov/doc/09annual.pdf

FIGURE 8: Percent of Births to Women Receiving Late or No Prenatal Care by Race, Tri-County, Maryland, 2009



Source: Maryland Vital Statistics Administration. (2010). *Annual Report 2009*. http://vsa.maryland.gov/doc/09annual.pdf

FIGURE 9: Percent of Births to Women Receiving Late or No Prenatal Care by Race, Maryland, 2000-2009



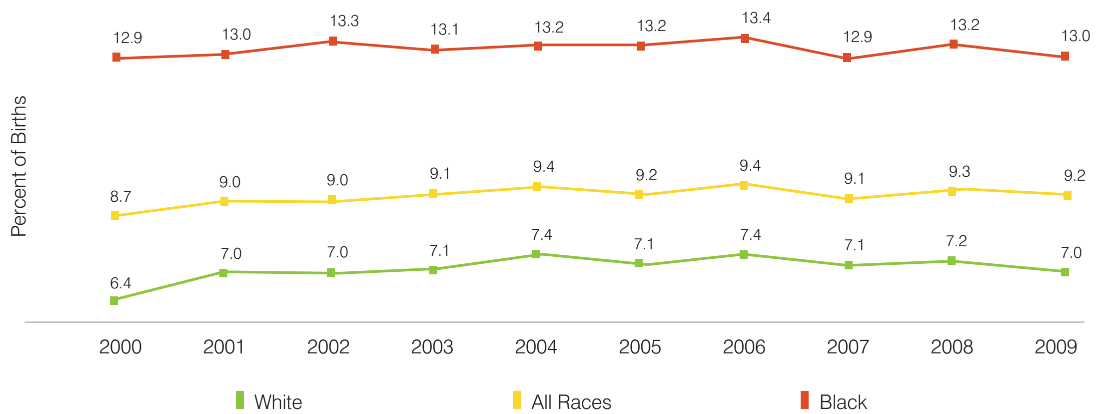
Source: Maryland Vital Statistics Administration. (2010). *Annual Report 2009*. http://vsa.maryland.gov/doc/09annual.pdf

Low Birth Weight

According to the Centers for Disease Control and Prevention, low birth weight is the single most important factor correlating with infant morbidity.[10] Babies born weighing less than 2,500 grams who survive are at a higher risk for serious health problems than those infants who are born at healthy weights.

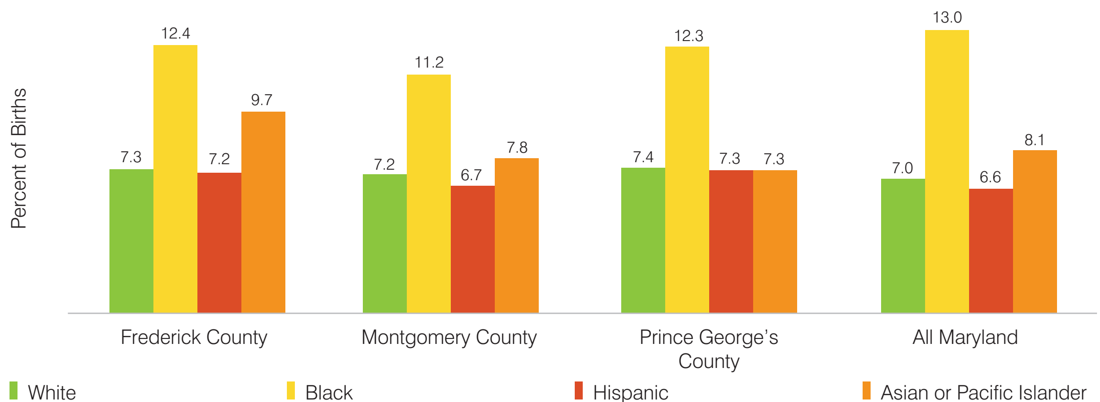
- The percent of babies born with low birth weight increased very slightly among all racial groups in Maryland between 2000 and 2009, potentially due to the fact that rates of early prenatal care are decreasing. [Figure 10]
- Black mothers delivered low birth weight babies almost twice as often as white mothers in 2009. [Figure 10]
- Across all three counties, rates of low birth weight are lowest among Hispanic women. [Figure 11]

FIGURE 10: **Low Birth Weight Births by Race, Maryland, 2000-2009**



Source: Maryland Vital Statistics Administration. (2010). *Annual Report 2009*. http://vsa.maryland.gov/doc/09annual.pdf

FIGURE 11: **Low Birth Weight Births by Race/Ethnicity, Tri-County, Maryland, 2009**



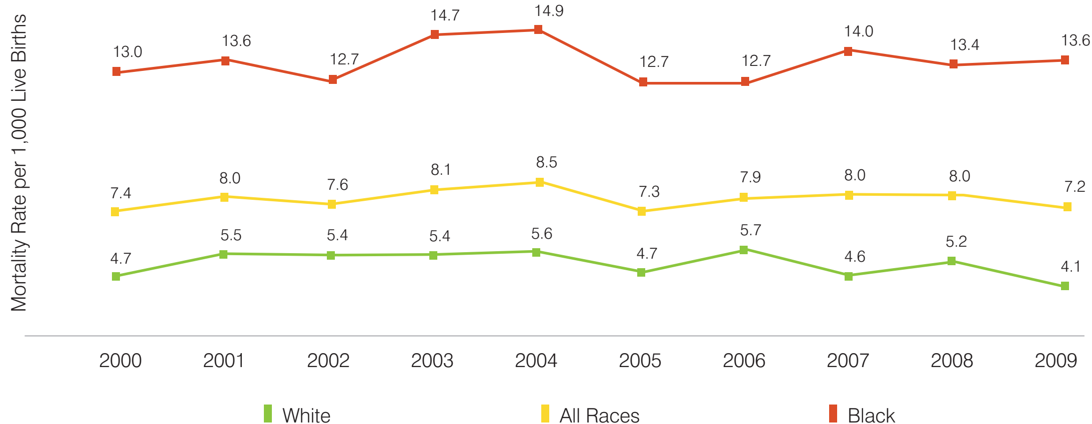
Source: Maryland Vital Statistics Administration. (2010). *Annual Report 2009*. http://vsa.maryland.gov/doc/09annual.pdf

Infant Mortality

Despite advanced medical knowledge and technology, infant mortality continues to persist as a problem for minority populations in the United States. This is a particular concern for blacks across the country, as well as in Maryland, as the infant mortality rate in this group is significantly higher than for any other racial or ethnic group.

- Despite the fact that more women are going without prenatal care, the infant mortality rate in Maryland overall and for white mothers has decreased slightly since 2000. [Figure 12]
- The infant mortality rate per 1,000 live births among black women in Montgomery County in 2005 was 14.9; in 2009, this figure dropped to 10.7 per 1,000. While this rate is still the highest among all racial groups in the county, the rate has declined almost 30 percent over four years, indicating a significant improvement in neonatal care. [Figure 13]
- Prince George's County is the only county in the tri-county area in which infant mortality rates among whites and Hispanics are higher than the overall Maryland average in 2009. [Figure 13]

FIGURE 12: **Infant Mortality Rate by Race, Maryland, 2000-2009**



Source: Maryland Vital Statistics Administration. (2010). *Annual Report 2009*. http://vsa.maryland.gov/doc/09annual.pdf

FIGURE 13: **Infant Mortality Rate per 1,000 Live Births by Race/Ethnicity, Tri-County, Maryland, 2009**

COUNTY	WHITE	BLACK	HISPANIC
Frederick	3.4	**	**
Montgomery	3.9	10.7	1.3
Prince George's	6.0	11.1	6.0
All Maryland	4.1	13.6	3.1

**Rates based on fewer than five events in the numerator are not presented since such rates are likely to be unstable

Source: Maryland Vital Statistics Administration. (2010). *Annual Report 2009*. http://vsa.maryland.gov/doc/09annual.pdf

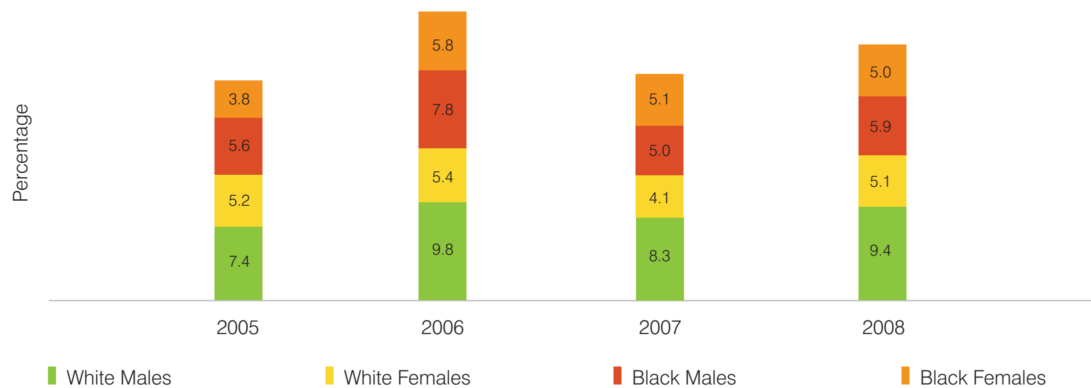
Heart Disease and Stroke

In Maryland, heart disease and stroke affect different segments of the population disproportionately based on race, ethnicity, and gender. White males tend to have the highest prevalence rates of coronary heart disease, while blacks have the highest death rate for diseases of the heart, which suggests that minorities receive worse care, experience greater disease severity levels and, ultimately, worse health outcomes.[11] However, improvements in treatment have reduced the death rate for diseases of the heart between 2000 and 2009 by 22 percent among whites and 26 percent among blacks in Maryland.

Coronary Heart Disease

- Coronary heart disease was most common among men in 2008. White males in particular are more likely to suffer from this condition than any other group. [Figure 14]

FIGURE 14: **Prevalence of Coronary Artery Disease by Race and Gender, Maryland, 2005-2008**



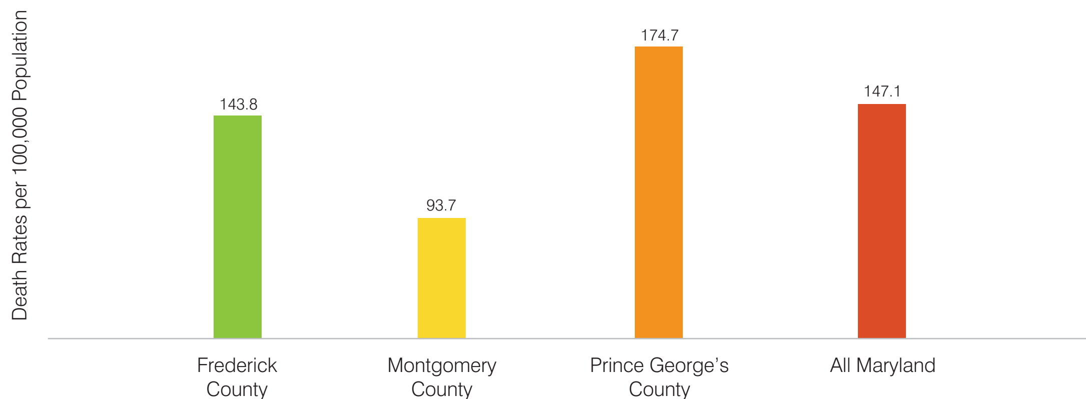
Source: Maryland Department of Health & Mental Hygiene. (2009). "The Maryland Burden of Heart Disease and Stroke." Family Health Administration, Office of Chronic Disease Prevention. http://fha.maryland.gov/pdf/cdp/Report-Heart-Stroke.pdf

KEY TAKEAWAYS

- Similar to data in national statistics, heart disease and stroke affect Maryland's white population more than its black population.
- Although incidence rates have declined among all racial and ethnic groups in the state over the last several years, blacks experience high death rates for diseases of the heart.
- Similarly, minority populations experience more of the negative effects of stroke: differences in stroke incidence rates are nominal between racial and ethnic groups, yet blacks have a significantly higher cerebrovascular disease death rate than whites.

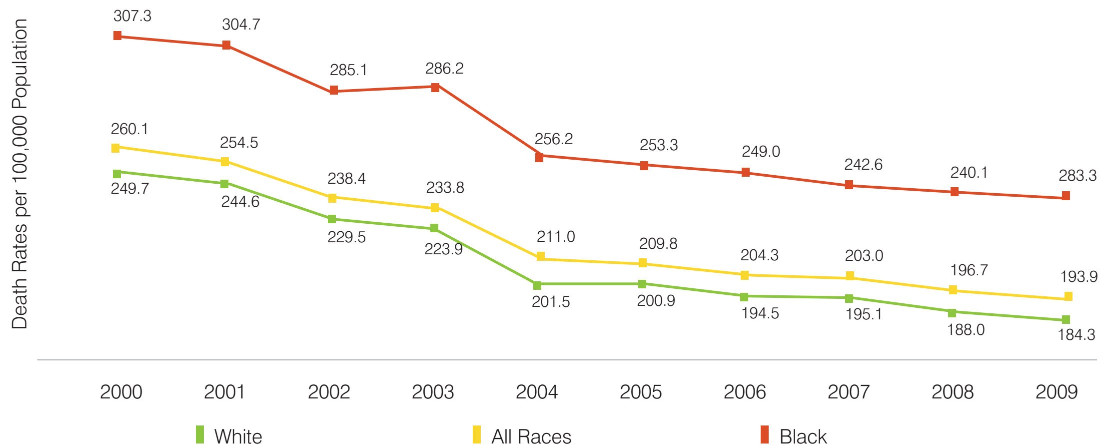
- In 2008, the death rate from coronary heart disease in Prince George's County was higher than it was in Montgomery and Frederick Counties. The death rate was also higher than the Maryland average. This fact is notable because Prince George's is a predominantly minority county and, on average across Maryland, white males have the highest prevalence of coronary heart disease. This suggests that residents of Prince George's County may have less access to effective healthcare services to detect and treat the disease. [Figure 15]
- However, treatment in general is improving because over the last decade, diseases of the heart have resulted in about a quarter fewer deaths across Maryland. [Figure 16]

FIGURE 15: Coronary Heart Disease Death Rate, Tri-County, Maryland, 2008



Source: Maryland Department of Health & Mental Hygiene. (2009). "The Maryland Burden of Heart Disease and Stroke." Family Health Administration, Office of Chronic Disease Prevention. http://fha.maryland.gov/pdf/cdp/Report-Heart-Stroke.pdf

FIGURE 16: Death Rate for Diseases of the Heart by Race, Maryland, 2000-2009

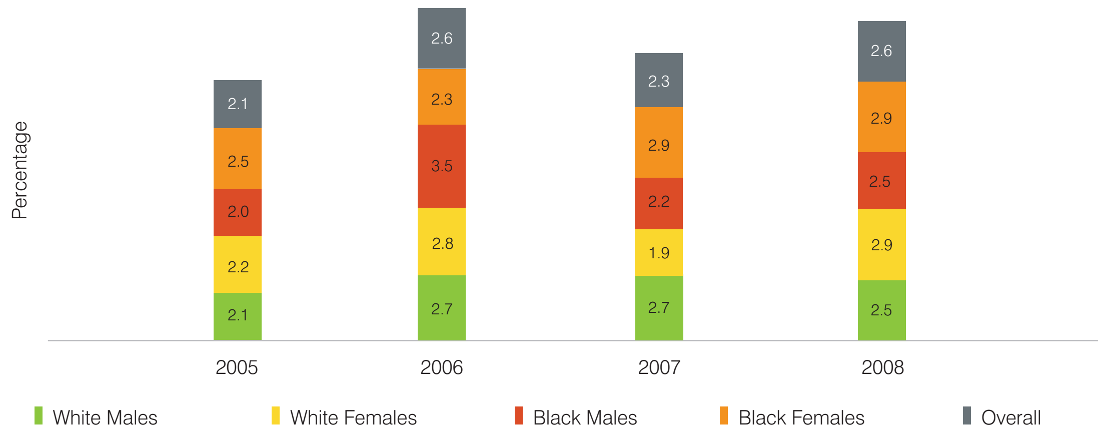


Source: Maryland Department of Health & Mental Hygiene. (2009). "The Maryland Burden of Heart Disease and Stroke." Family Health Administration, Office of Chronic Disease Prevention. http://fha.maryland.gov/pdf/cdp/Report-Heart-Stroke.pdf

Stroke

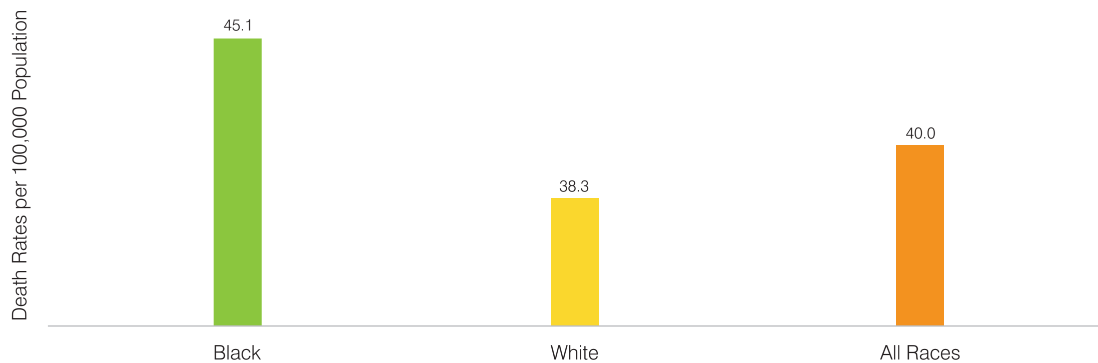
- Unlike coronary heart disease, the prevalence of stroke in Maryland differs nominally among racial and ethnic groups, as well as across years. [Figure 17]
- Nonetheless, black residents had the highest cerebrovascular death rate in Maryland in 2008, at 45.1, compared to 38.3 for white residents. [Figure 18]

FIGURE 17: **Prevalence of Stroke by Race and Gender, Maryland, 2005-2008**



Source: Maryland Department of Health & Mental Hygiene. (2009). "The Maryland Burden of Heart Disease and Stroke." Family Health Administration, Office of Chronic Disease Prevention. http://fha.maryland.gov/pdf/cdp/Report-Heart-Stroke.pdf

FIGURE 18: **Age-Adjusted Death Rate for Cerebrovascular Diseases by Race, Maryland, 2008**



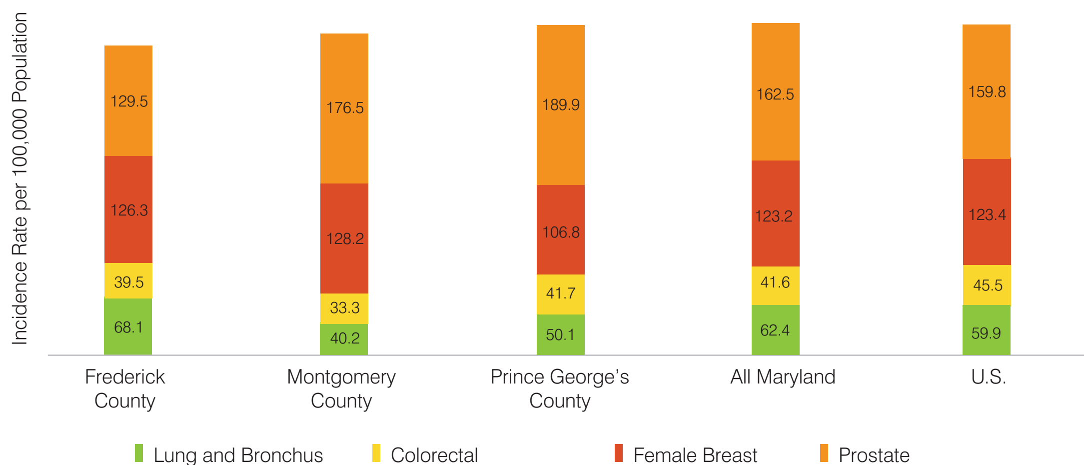
Source: Maryland Department of Health & Mental Hygiene. (2009). "The Maryland Burden of Heart Disease and Stroke." Family Health Administration, Office of Chronic Disease Prevention. http://fha.maryland.gov/pdf/cdp/Report-Heart-Stroke.pdf

- In the tri-county area, mortality due to stroke was highest in Frederick County (44.6), which has a larger proportion of white residents than Montgomery or Prince George's Counties. The death rates due to stroke in those counties are 31.4 and 33.8, respectively. The stroke death rate in Frederick County was substantially higher than the Maryland average (40.0).[12]

Cancer

The National Institutes of Health's National Cancer Institute defines "cancer health disparities" as adverse differences in cancer incidence, cancer prevalence, cancer death, cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups in the United States."[13] Although the overall cancer incidence rate in Maryland has declined steadily over the years—at a pace comparable to the decline in the U.S. rate—data indicate clearly that there are health disparities in the state. Aggregate cancer incidence rates are comparable across the tri-county region, but this is not true for mortality. [Figures 19 and 20]

FIGURE 19: **Cancer Incidence Rates, Tri-County, Maryland and U.S., 2007**

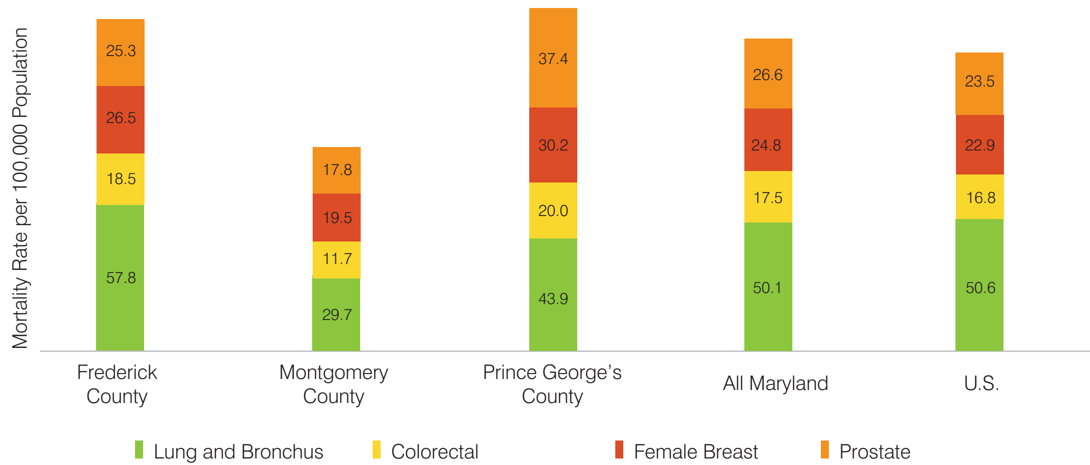


Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

KEY TAKEAWAYS

- Overall, cancer incidence rates are declining in Maryland.
- In the tri-county region, incidence rates of cancer are similar, but mortality rates are not. Prince George's County has the highest mortality rates for three out of four cancers analyzed.
- Despite clearly poor health outcomes among certain racial and ethnic groups in particular regions of the state, great strides have been made in the African American community over the years. Both cancer incidence and mortality rates for this group have declined more significantly than among white residents, suggesting that efforts to educate residents about the importance of screening and regular medical care following a cancer diagnosis have been effective.

FIGURE 20: Cancer Mortality Rates, Tri-County, Maryland and U.S., 2007



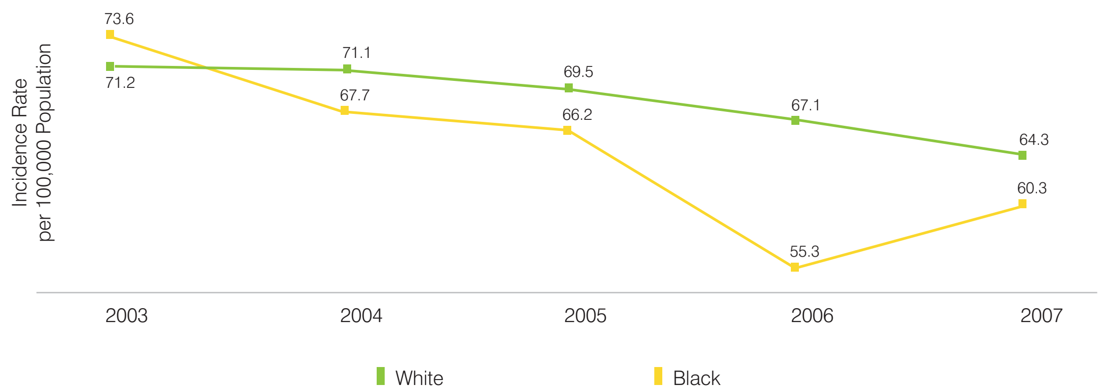
Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

Lung Cancer

Lung cancer is the leading cause of cancer-related death for both men and women in Maryland. However, the incidence and mortality rates of lung cancer have decreased in the state, with the incidence rate among black individuals declining more rapidly than among whites. [Figures 21 and 22]

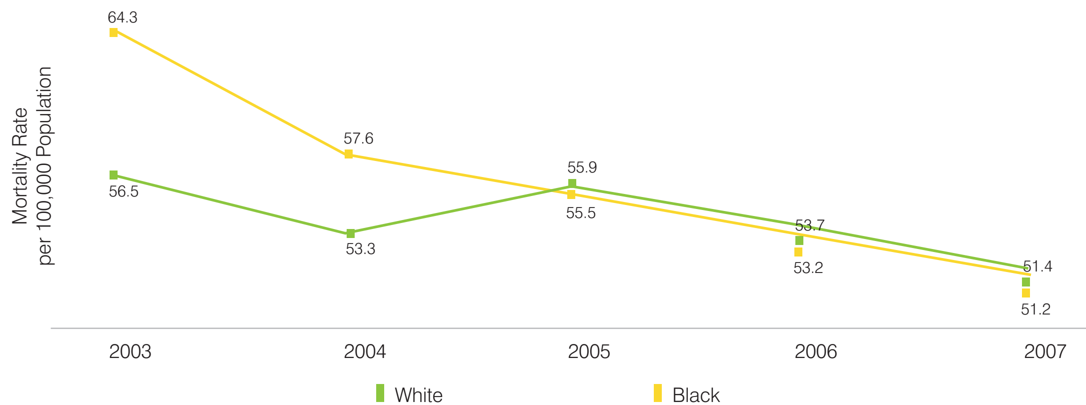
- Between 2003 and 2007, the incidence rate of lung and bronchus cancer among blacks in Maryland declined by nearly 21 percent. In contrast, the incidence rate for white residents of the state went down by about seven percent during the same time period. Blacks in Maryland now have a lower incidence rate of lung cancer than do whites and both groups have nearly equal mortality rates.

FIGURE 21: Lung and Bronchus Cancer Incidence Rate by Race, Maryland, 2003-2007



Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

FIGURE 22: **Lung and Bronchus Cancer Mortality Rate by Race, Maryland, 2003-2007**



Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

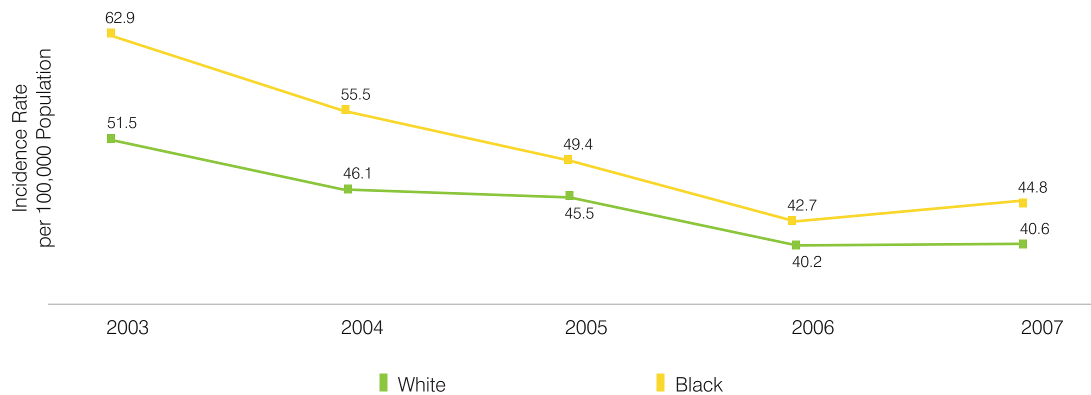
- The incidence of lung cancer is highest among whites in the tri-county region, except in Montgomery County, where blacks are more likely to have the disease than other racial groups.
- Similarly, black residents of Montgomery County die from lung cancer more frequently than whites (39 percent versus 29.6 percent), differing from the overall state trend, which indicates that blacks and whites have relatively equal mortality rates for this type of cancer. The highest lung and bronchus cancer mortality rate, however, is experienced by white people in Frederick County (58.2 percent).

In the tri-county region, incidence rates of cancer are similar, but mortality rates are not. Prince George's County has the highest mortality rates for three out of four cancers analyzed.

Colorectal Cancer

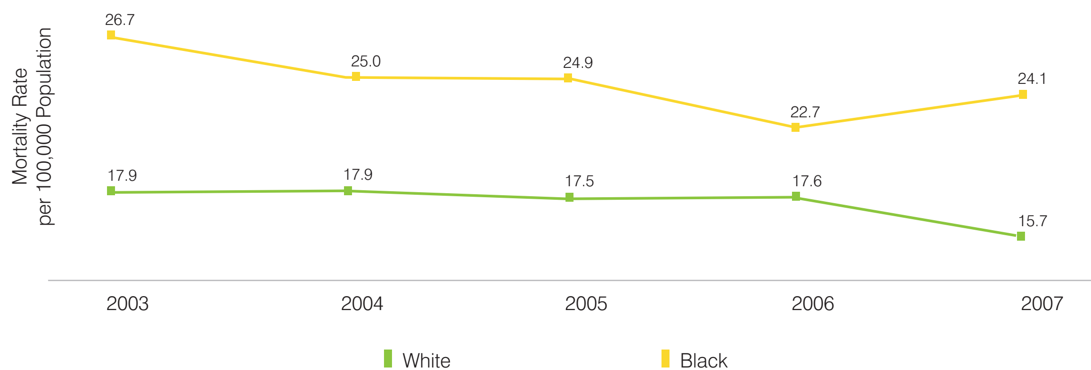
Incidence and mortality rates for colorectal cancer declined in Maryland between 2003 and 2007, with incidence among black individuals decreasing more significantly than whites. [Figures 23 and 24] This is likely due to the fact that Maryland surpasses the Healthy People 2010 target for colorectal cancer screening; at least 70 percent of adults of all races over the age of 50 underwent a sigmoidoscopy or colonoscopy in 2008. [Figure 25] Colorectal cancer is largely preventable with screening tests, which find precancerous growths early enough to either cure the disease or prevent further cancerous growth with surgery.

FIGURE 23: **Colorectal Cancer Incidence Rate by Race, Maryland, 2003-2007**



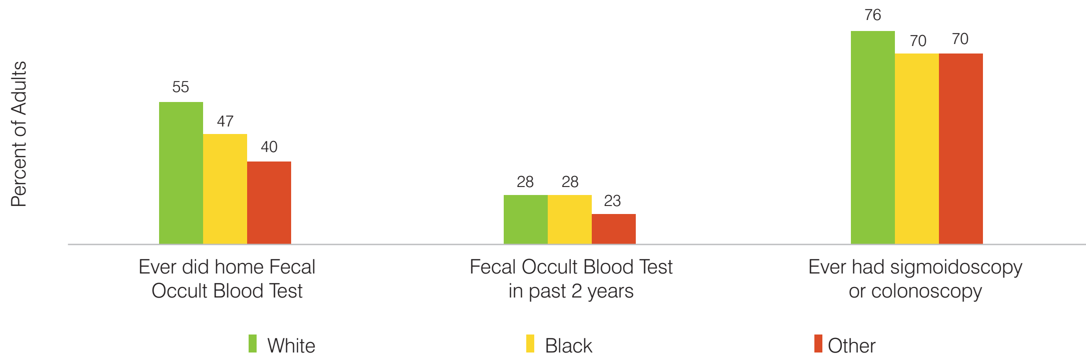
Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

FIGURE 24: **Colorectal Cancer Mortality Rate by Race, Maryland, 2003-2007**



Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). Cancer Report, 2010 Revised. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

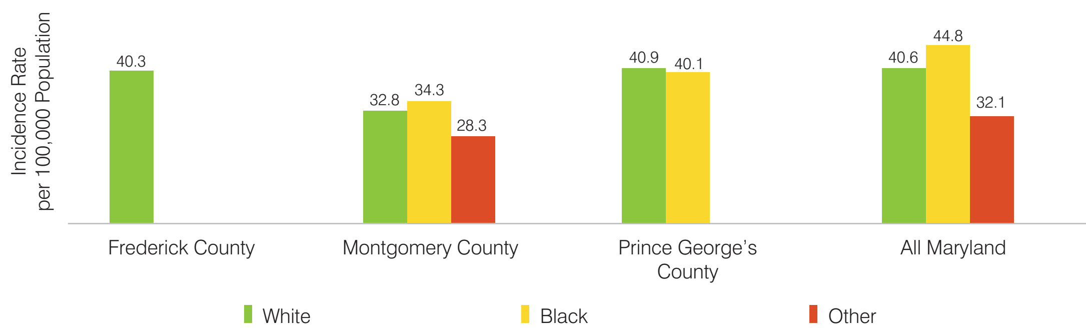
FIGURE 25: **Prevalence of Colorectal Cancer Screening among Adults Age 50 and Older by Race, Maryland, 2008**



Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. "Other" includes Asian/Pacific Islander and Native Americans.
Source: Maryland Department of Health & Mental Hygiene. (2009). Maryland Cancer Survey, 2008. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/2008_MCS_Report.pdf

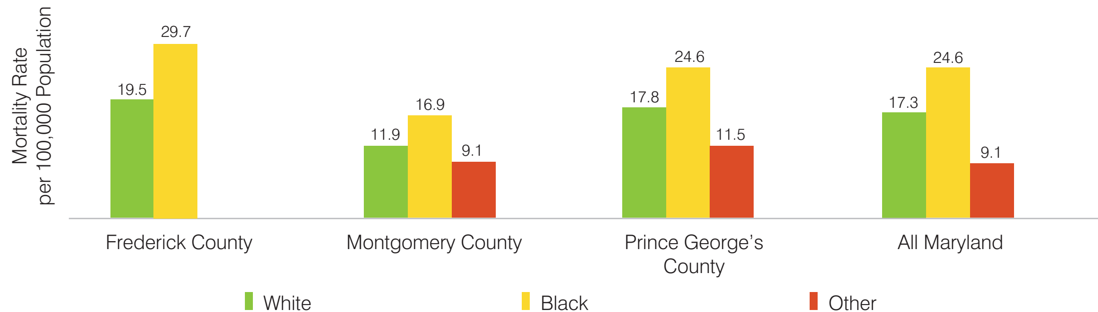
- Although the screening for and incidence of colorectal cancer among all races in the three counties is relatively comparable, mortality rates were much higher for blacks than whites or other races in 2007, indicating that blacks may be getting systematically less or inferior follow-up care post screening. [Figures 26 and 27]

FIGURE 26: **Colorectal Cancer Incidence Rates by Race, Tri-County, Maryland, 2007**



Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Data for "other" (which includes Asian/Pacific Islander and Native Americans) were either unavailable or suppressed, due to case counts of 1-15. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

FIGURE 27: **Colorectal Cancer Mortality Rates by Race, Tri-County, Maryland, 2007**



Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Data for "other" (which includes Asian/Pacific Islander and Native Americans) were either unavailable or suppressed, due to case counts of 1-15. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

Prostate Cancer

Following lung cancer, prostate cancer is the second leading cause of cancer deaths among men in Maryland; the state ranked 11th in the country for prostate cancer mortality. Between 2003 and 2007, prostate cancer incidence and mortality rates declined among both white and black men, but black men in the state still get diagnosed with and die from prostate cancer more often than whites. In 2007, the incidence rate of prostate cancer for black men was 209 per 100,000 male population, nearly 30 percent higher than the incidence rate among white men (146.5).

The racial disparities seen in prostate cancer incidence and mortality rates across the state are not surprising, given the fact that black men and men of other races are screened for the disease less frequently than are white men. For example, in 2007, 49 percent of black men age 45 and older in Maryland indicated that they had undergone a prostate-specific antigen (PSA) test in the last year, while just over 60 percent of white men had the test.[14]

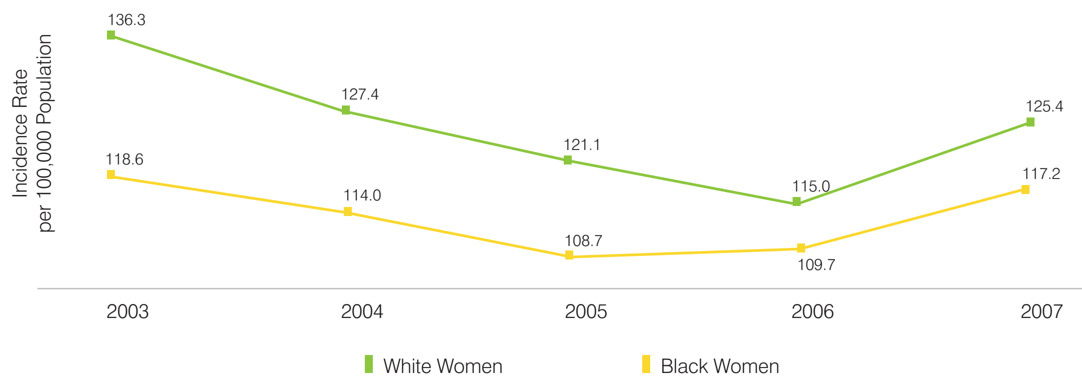
Following lung cancer, prostate cancer is the second leading cause of cancer deaths among men in Maryland; the state ranked 11th in the country for prostate cancer mortality.

Cancers Affecting Women

Breast Cancer

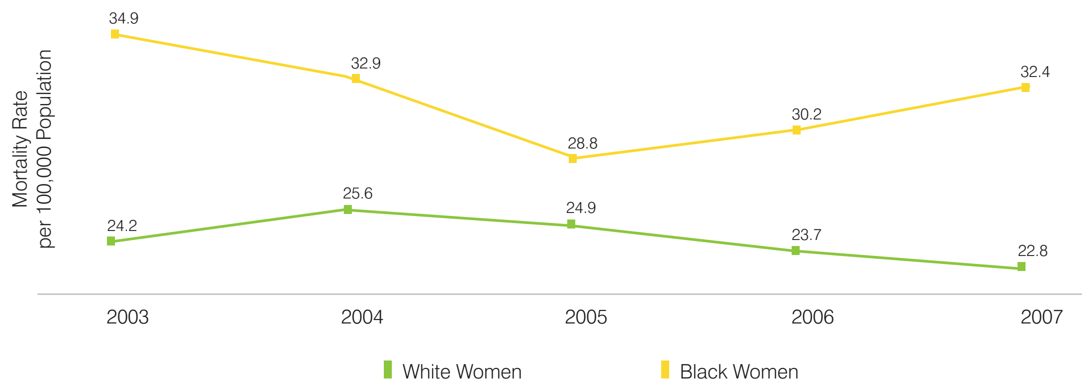
Maryland ranks sixth in the nation for breast cancer mortality in the United States; in fact, breast cancer is the second leading cause of cancer deaths among Maryland women after lung cancer. Incidence and mortality rates of the disease declined across the state from 2003 to 2007, narrowing the gap between white and black women. [Figures 28 and 29] This is likely a result of the fact that black women over the age of 50 in Maryland report having had mammograms more frequently than white women. [Figure 30]

FIGURE 28: **Breast Cancer Incidence Rate by Race, Maryland, 2003-2007**



Rates are per 100,000 and are age-adjust Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

FIGURE 29: **Breast Cancer Mortality Rate by Race, Maryland, 2003-2007**



Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

- The percent of all women over age 50 in Maryland who report having had a mammogram in the last two years (just over 78 percent) lags behind the national average (about 82 percent). [Figure 30]

FIGURE 30: **Women Age 50+ Reporting Having Had Mammogram in Last 2 Years by Race, 2010**

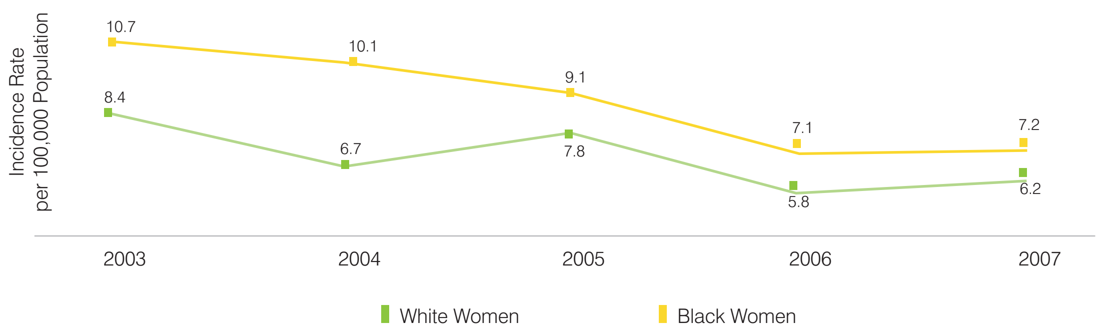
The state sample of Hispanic women was fewer than 100 respondents, making the data insufficient for inclusion. Source: Kaiser Family Foundation. (2010). Mammogram Rate by Rate/Ethnicity. State Health Facts 2010. http://www.statehealthfacts.org/comparebar.jsp?ind=481&cat=10

- Despite the marginal improvements in incidence and mortality rates over the last five years, black women in the tri-county region died from breast cancer at much higher rates than white females in 2007. In Montgomery County, the breast cancer mortality rate among black women is 28.8, compared to 19.9 for white women. Similarly, in Prince George's County, the mortality rate for black was 33.6 compared to 25.3 for whites. These mortality rates generally mimic those experienced by black and white women across the state.[15]

Cervical Cancer

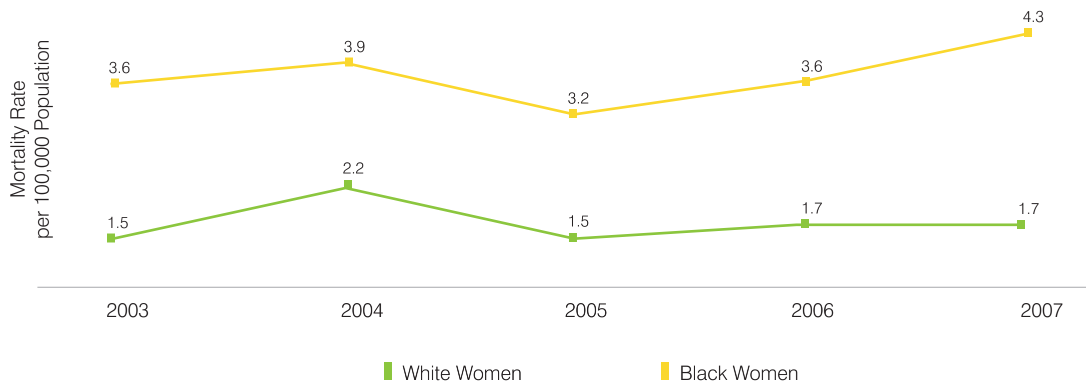
Between 2003 and 2007, cervical cancer incidence rates decreased among Maryland women, bringing the state's overall incidence rate (6.4 percent) lower than the national average (7.8 percent). [Figure 31] However, mortality rates for cervical cancer increased during this time period, particularly for black women. [Figure 32] This inverse relationship between incidence and mortality is further complicated by the rate at which Maryland women are screened for cervical cancer: in 2010, the vast majority of both white and black women over the age of 18 had a pap test in the last three years, at rates higher than or in-line with the Healthy People 2010 target. [Figure 33] These combined data points may suggest that women—especially blacks—receive poor care following diagnosis of cervical cancer. In fact, studies have shown that despite abundant healthcare resources in the United States, women who belong to minority groups or are socioeconomically disadvantaged have not equally benefited from Pap smear screening. This is usually due to the presence of comorbid diseases and failure to have follow-up visits for colposcopic evaluation.[16]

FIGURE 31: **Cervical Cancer Incidence Rate by Race, Maryland, 2003-2007**



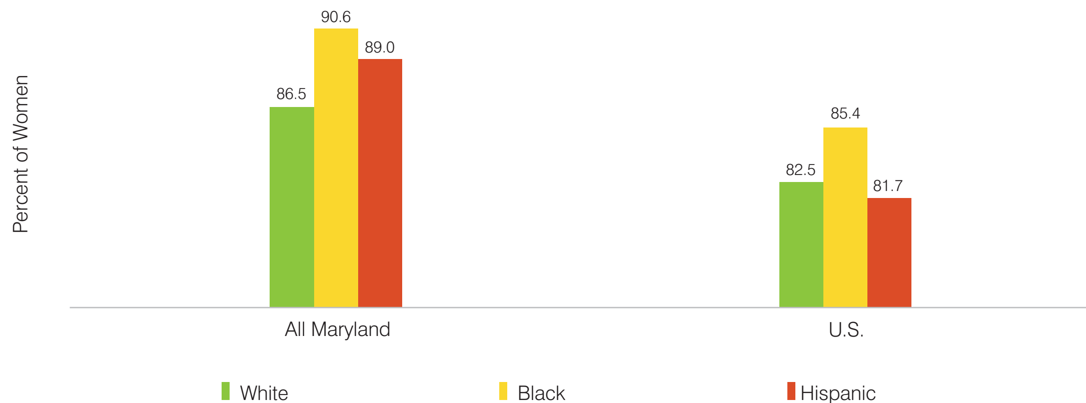
Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

FIGURE 32: **Cervical Cancer Mortality Rate by Race, Maryland, 2003-2007**



Rates are per 100,000 and are age-adjusted to 2000 U.S. standard population. Source: Maryland Department of Health & Mental Hygiene. (2011). *Cancer Report, 2010 Revised*. Cigarette Restitution Fund Program. http://fha.maryland.gov/pdf/cancer/CRF_Cancer_Report_2010.pdf

FIGURE 33: **Women 18+ Reporting Having Had Pap Test in Last 3 Years by Race/Ethnicity, 2010**



The state sample of Asian or Pacific Islander women was fewer than 100 respondents, making the data insufficient for inclusion. Source: Kaiser Family Foundation. (2010). Pap Smear Rate by Race/Ethnicity. State Health Facts. http://www.statehealthfacts.org/comparebar.jsp?ind=481&cat=10

Conclusions

Over the last several years, Maryland has made significant progress in eliminating health disparities among various racial and ethnic groups. Incidence and mortality rates for a number of health conditions and diseases have declined, and more and more people are participating in life-saving health screenings. However, racial and ethnic minorities in the tri-county area—and across the state—are still disproportionately affected by poor health outcomes compared to non-minority individuals. It is critically important that community leaders understand why disparities persist and target their underlying causes, especially as minority populations across the country continue to expand.

Chapter Two

The ACA addresses health disparities through its provisions to expand health insurance coverage, improve quality of care, and reduce costs.

Background on the Affordable Care Act (ACA) Provisions that Address Health Equity

THE ACA ADDRESSES HEALTH DISPARITIES THROUGH ITS PROVISIONS TO EXPAND HEALTH INSURANCE coverage, improve quality of care, and reduce costs. While most provisions of the ACA do not directly address racial and ethnic health disparities, the law offers a comprehensive framework to improve health equity by improving coverage and quality of care for all underserved populations.

- **Coverage.** The ACA will greatly expand access to health insurance coverage through the creation of new insurance options and the expansion of existing public programs. The Congressional Budget Office has estimated that there will be 33 million fewer uninsured individuals in 2019 than there would have been under prior law.[17] Minority populations are overrepresented in the uninsured population, and may see greater gains in coverage under the ACA.
- **Quality.** The ACA aims to improve the quality of care delivery by increasing the focus on prevention, encouraging quality measurement and reporting requirements, making care more patient-centered, and promoting appropriate use of evidence-based clinical guidelines.
- **Affordability.** The ACA covers people with limited income through assistance programs that will reduce premiums and cost-sharing for eligible individuals and families. The law also provides cost-sharing protections that will limit out-of-pocket spending for enrollees of many health insurance plans.

Table 1 shows the many provisions of the ACA that, either through direct or indirect means, aim to reduce health disparities or promote health equity in the healthcare system.

In addition to provisions that aim to improve health systems and healthcare, the ACA also reinforces the infrastructure within the U.S. Department of Health and Human Services (HHS) to better coordinate efforts across agencies within the department. Minority health offices have been established in six agencies (Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), Centers for Medicare & Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Association (SAMHSA)). Further, the National Center on Minority Health and Health Disparities was elevated to an institute within the National Institutes of Health (NIH). These offices and institutes will now be able to harmonize their principles and functions to minimize the silos that often come with sharing a mission across agency walls. There are also many provisions designed specifically to address disparities or to collect further information about populations at risk for health disparities.

TABLE 1.

The ACA Expands Access to Insurance Coverage

General Access

- Pre-Existing Condition Insurance Plans
- State Health Insurance Exchanges
- Premium Tax Credits
- Cost-Sharing Reductions
- Limits on Out-of-Pocket Spending
- Expansions to Medicaid

The ACA Expands Access to Care

Access in Medically Underserved Areas

- Medicare Bonuses for Primary Care and Surgical Services
- Payment Adjustments for Home Health Care
- Nurse Managed Health Clinics

Access for Populations with Limited Income

- School-Based Health Centers
- Federal Coordinated Health Care Office
- Community Health Centers and the National Health Services Corps Fund
- Expanded 340B Eligibility

Addressing Language and Cultural Barriers

- Uniform Plan Reference Documents
- Exchange Activities to Reduce Disparities
- Model Cultural Competence Curricula

The ACA Encourages Quality Measures and Adherence to Guidelines

Development of Quality Measures and Implementation

- National Strategy to Improve Healthcare Quality for People with Chronic Conditions
- Interagency Working Group on Healthcare Quality
- Quality Measure Development
- Quality Improvement Technical Assistance
- Patient-Centered Outcomes Research Institute

Reporting Requirements

- Health Disparities Data Collection and Analysis
- Offices of Minority Health

The ACA Promotes Appropriate Care

Care in Communities

- Maternal, Infant, and Early Childhood Home Visiting Programs
- Community Health Teams in Medicaid
- Community Transformation Grants

Prevention

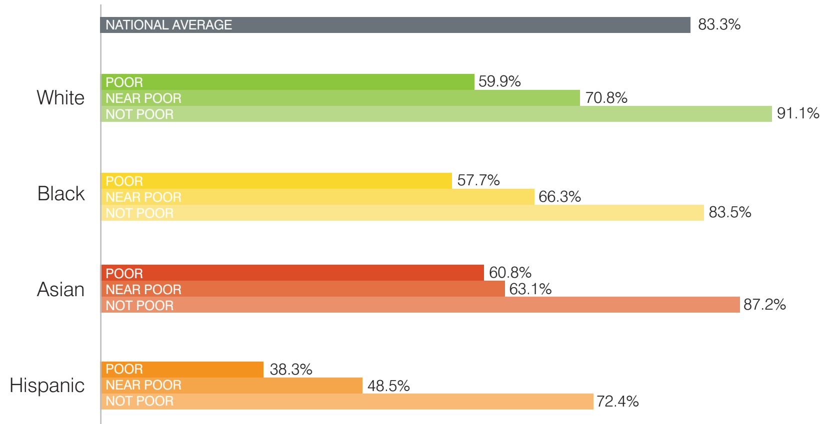
- Increased Access to Preventive Services
- Prevention and Public Health Fund
- Incentives for Prevention of Chronic Conditions in Medicaid

The ACA Expands Access to Insurance Coverage

Findings from the National Healthcare Quality and Disparities Reports have shown that lack of health insurance is a significant factor contributing to poor quality of care. Uninsured people are less likely to receive recommended care for disease prevention or for disease management.[18]

In 2009, there were nearly 50 million uninsured Americans. Between 2004 and 2009, the percentage of people with health insurance dropped slightly from 85.1 percent to 83.3 percent. While low-income individuals experience disproportionate levels of uninsurance, levels of insurance also vary greatly by race and ethnicity as well as income. In fact, even at moderate to high income levels (i.e., above 250 percent of the federal poverty level, or FPL), rates of insurance coverage are markedly lower for both black and Hispanic populations. Additionally, the Hispanic population across income levels exhibits striking differences in its rates of insurance compared to the rest of the population.[19] Figure 43 illustrates how rates of health insurance coverage for adults at different income levels differ by race and ethnicity.

FIGURE 34: **Health Insurance Coverage of Adults, by Race/Ethnicity and Income Level, 2009**



Note: POOR is defined as income below 100% FPL; NEAR POOR is defined as income between 100% FPL and 250% FPL. NOT POOR is defined as income above 250% FPL

Source: U.S. Census Bureau. (2010). Current Population Survey, Annual Social and Economic Supplement.

Access to health insurance coverage is clearly an issue for people with limited income. However, across limited income levels, racial and ethnic minorities have lower rates of health insurance coverage than the national average. [Figure 34] Increasing access to health insurance coverage will remove some barriers that people have in accessing care itself.

General Access

The ACA created two programs to provide health insurance coverage regardless of income status. The first program, the Pre-Existing Condition Insurance Plans, offers immediate coverage for chronically ill individuals who do not have access to other sources of insurance. The second program, the state exchanges, will offer a marketplace of coverage options for individuals and small businesses beginning in 2014.

Pre-Existing Condition Insurance Plans

Beginning in 2010, the ACA established a temporary high-risk pool program—known as the Pre-Existing Condition Insurance Plan (PCIP)—to provide affordable coverage to uninsured individuals with serious medical conditions through 2014, when state exchanges will begin operations. The law appropriated $5 billion for HHS to fund the operation of the PCIPs. States had the option to run their own PCIP or have HHS run it for them. Twenty-seven states elected to operate their own high-risk pools, while the plans in the remaining states are operated by the federal government.

To date, enrollment in PCIPs has been significantly below expectations. According to HHS, 33,958 individuals have enrolled in PCIPs nationwide as of August 31, 2011.[20] Enrollment is well below the expectations for this program; in fact, the Congressional Budget Office has predicted that up to four million individuals are eligible to enroll in PCIPs.

While initial enrollment in the PCIPs has been low, the federal government has recently focused on promoting enrollment of chronically ill individuals. High plan premiums have been cited as one reason for this low initial program enrollment. In 2011, states and the federally-run PCIP have responded to criticism by revising benefit options to increase deductibles or cost-sharing and reduce overall premiums. The PCIPs are the only major provision of the ACA that will increase insurance coverage before the major expansions occur in 2014.

State Health Insurance Exchanges

The ACA requires each state to establish a health benefit exchange (“exchange”) by January 1, 2014. States must design exchanges to facilitate the purchase of health insurance coverage for individuals as well as for small employers. The Congressional Budget Office has estimated that exchanges will serve approximately 24 million individuals by 2019 and 3.7 million employees who work for small firms.

In July 2011, HHS released a proposed regulation setting forth requirements for state implementation of exchanges. The regulations afford states nearly as much flexibility as was feasible under the statutory requirements. As such, exchange structures are likely to vary greatly from state to state. States have the flexibility to determine exchange governance structures, the bidding process for participating plans, funding sources, and plan provider network requirements.

As the state legislative sessions have ended for 2011, only about half of states have taken action to begin creating exchanges. Other states have explored alternate options of establishing exchanges, including executive orders.

Premium Tax Credits

The ACA establishes refundable premium assistance tax credits for health insurance coverage for individuals with household income between 100 percent and 400 percent FPL. To be eligible for premium tax credits, individuals must be citizens or lawful U.S. residents, and they must enroll in qualified health plans through state exchanges.

The premium tax credit is an amount that caps the individual's premium contribution based on a percentage of household income. [Table 2] For each income tier, the corresponding percent of household income is determined on a linear sliding scale. When an individual qualifies for a premium tax credit, the federal government will send the credited amount directly to the health plan in which the individual enrolls.

TABLE 2.

HOUSEHOLD INCOME TIER	RANGE OF PREMIUM CONTRIBUTIONS (PERCENT OF HOUSEHOLD INCOME)
Up to 133% FPL	2%
133% up to 150% FPL	3% to 4%
150% up to 200% FPL	4% to 6.3%
200% up to 250% FPL	6.3% to 8.05%
250% up to 300% FPL	8.05% to 9.5%
300% up to 400% FPL	9.5%

Cost-Sharing Reductions and Limits to Out-of-Pocket Spending

The ACA also creates a system to reduce cost sharing for individuals eligible for the premium assistance tax credit. To be eligible for cost-sharing reductions, individuals must be enrolled in a silver plan in the individual market offered through a state exchange.[21] When an individual qualifies for reductions in cost sharing, the federal government will notify the health plan of an individual's eligibility, and the plan is responsible for reducing the individual's cost-sharing amounts.

The amount of the cost-sharing reduction varies by income. The ACA establishes out-of-pocket cost sharing limits for enrollees in qualified health plans. [Table 3] For individuals with incomes between 100 percent and 200 percent of FPL, the out-of-pocket maximum is to be reduced by two-thirds. For those between 200 percent through 300 percent of FPL, it will be reduced by one-half. And, for those between 300 percent and 400 percent of FPL, it will be reduced by one-third.

TABLE 3.

HOUSEHOLD INCOME TIER	REDUCTION IN OUT-OF-POCKET MAXIMUM
100% to 200% FPL	2/3 of the maximum
200% to 300% FPL	1/2 of the maximum
300% to 400% FPL	1/3 of the maximum

For individuals and families with limited income (between 100 percent FPL and 250 percent FPL), the ACA also ensures that the actuarial value of the silver plan is more generous. [Table 4] The cost to plans to reduce cost-sharing for low-income individuals will be borne by the federal government.

TABLE 4.

HOUSEHOLD INCOME TIER	ADJUSTED ACTUARIAL VALUE OF SILVER PLAN
100% to 150% FPL	94%
150% to 200% FPL	87%
200% to 250% FPL	73%

The ACA's provisions to make health insurance coverage affordable to individuals and families will help many people to access coverage and care. The majority of uninsured people under 400 percent FPL is from racial and ethnic minority populations and will have access to new coverage options and programs to assist in paying for new coverage. Premium subsidies and reduced out-of-pocket maximums will assist many racial and ethnic minorities to pay for health insurance coverage and care. [Figure 35]

FIGURE 35: Uninsured Adults, by Race/Ethnicity and Income, in Millions, 2009

- Individuals under 138% FPL are likely to be eligible for Medicaid in 2014
- Individuals between 138% and 250% FPL will be eligible for premium and cost-sharing subsidies in 2014
- Individuals between 250% and 400% FPL will be eligible for premium subsidies in 2014
- Individuals above 400% FPL will not be eligible for any cost assistance in 2014

Source: U.S. Census Bureau. (2010). Current Population Survey, Annual Social and Economic Supplement.

Expansions to Medicaid

In addition to the programs that create new sources of health insurance coverage, the ACA also broadens eligibility criteria for the Medicaid program, which provides health insurance coverage to the lowest-income individuals. The ACA significantly expands eligibility for the Medicaid program by requiring states to provide coverage to all non-Medicare eligible individuals under age 65 with incomes less than 133 percent of the FPL (i.e., approximately $30,000 for a family of four in 2011). States had the option of expanding their Medicaid programs to cover this population starting on April 1, 2010, and states are required to cover these individuals starting on January 1, 2014.

After 2014, the cost to pay for coverage for these newly eligible Medicaid enrollees will be almost completely funded by the federal government. The Medicaid program is financed through federal and state monies. However, the ACA applies an enhanced matching rate for these new enrollees. Beginning in 2014, states also will have the option of extending Medicaid coverage to individuals with incomes above 133 percent FPL who are not otherwise Medicaid eligible.

At the same time that eligibility criteria are broadened, the ACA also changes the methods for income calculations for Medicaid eligibility. The law adds a five percentage point disregard to income levels in order to calculate eligibility for Medicaid. In effect, this means that Medicaid eligibility is expanded to people under age 65 whose income is at or below 138 percent FPL. Of the 34.1 million people age 18 to 65 whose income is up to 138 percent FPL, 54.8 percent had health insurance coverage in 2009. In contrast, 87.9 percent of people age 18 to 65 whose income is above 250 percent FPL have health insurance coverage. Additionally, of the 16.6 million uninsured adults whose income is up to 138 percent, 57.8 percent are racial or ethnic minorities. [Figure 35]

The ACA's provisions to make health insurance coverage affordable to individuals and families will help many people to access coverage and care.

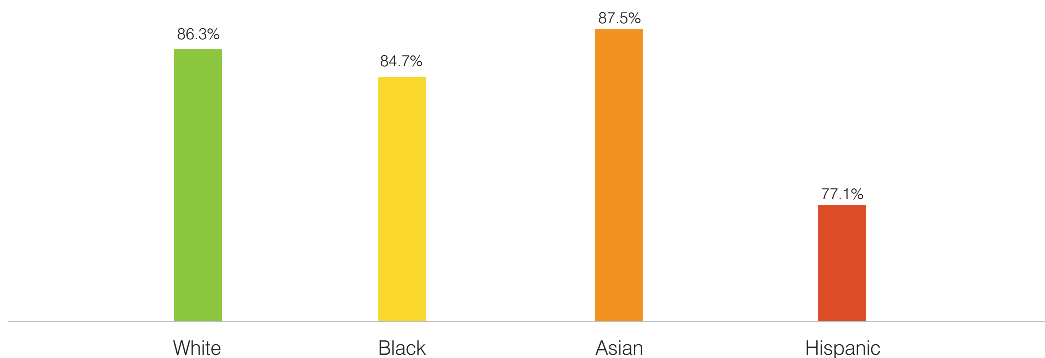
The ACA Expands Access to Care

In addition to access to health insurance coverage, access to the healthcare system itself is also a contributor to health equity. Measuring access to care is often achieved by examining whether people have a usual source of care—a provider or facility where someone typically goes to receive care. In fact, there is evidence that access to a usual source of care enhances quality of care for people with access to insurance coverage.[22]

In 2008, just over 86 percent of people had a specific usual source of care. [Figure 36] The rate of having a usual source of care was lower for black residents (84.7 percent) than for whites (86.3 percent). Additionally, the rate was significantly lower for Hispanics (77.1 percent) than for non-Hispanic whites (88.6 percent). Disparities also exist between people at different income levels. People with limited income reported a significantly lower rate of usual source of care (77.5 percent) than people with high income (92.1 percent).[23]

The ACA attempts to increase access to care for populations that are most likely to experience access barriers, including residents of rural and urban areas, low-income populations, populations with language or cultural barriers, and those who receive care in community health centers. Many of the provisions included in this section aim to improve access to care by offering incentives to those who provide health-care services to at-risk populations.

FIGURE 36: **Individuals Reporting a Usual Source of Care, by Race/Ethnicity, 2008**



Source: Agency for Healthcare Research and Quality (2011). *The National Healthcare Quality & Disparities Reports*. http://www.ahrq.gov/qual/qrdr10.htm.

Access in Medically Underserved Areas

The ACA offers incentives to certain healthcare providers who practice in medically underserved areas, including rural and urban communities.

Medicare Bonuses for Primary Care and Surgical Services

From 2011 through 2015, the ACA requires 10 percent bonus Medicare payments for primary care services provided by primary care physicians, as well as nurse practitioners, clinical nurse specialists, and physician assistants. During the same timeframe, the ACA also mandates 10 percent bonus Medicare payments for major surgical procedures for general surgeons who practice in places referred to as health professional shortage areas.

Payment Adjustments for Home Health Care

From April 2010 through 2015, the ACA provides a three percent bonus payment for home health providers serving rural areas.

Nurse Managed Health Clinics

The ACA establishes a new grant program to develop and support nurse-managed health clinics that will provide primary care or wellness services to underserved or vulnerable populations. In 2010, $15 million was awarded through 10 grants.

Access for Populations with Limited Income

People with limited income experience greater access challenges than middle and high-income populations. The ACA addresses this through many approaches – new sources of care, increased coordination, and changes to payment structures.

School-Based Health Centers

Between 2010 and 2013, the ACA provides $50 million per year for grants to establish the facilities for school-based health centers. The ACA requires HHS to give preference to grant applicants for school-based health centers that serve a large population of children eligible for Medicaid. From 2010 through 2014, the ACA also creates a grant program for the operation of school-based health centers.

Federal Coordinated Health Care Office

The ACA creates a Federal Coordinated Health Care Office within CMS. The purpose of this new office is to better integrate benefits under Medicare and Medicaid for people who are entitled to enroll in both programs. The office also aims to improve the federal-state coordination of benefits for individuals who are dually eligible for benefits under both programs.

Community Health Centers and the National Health Services Corps Fund

Between 2011 and 2015, the ACA provides funding to establish a Community Health Center Fund that will help expand and sustain community health centers and the National Health Service Corps.

Expanded 340B Eligibility

The 340B Drug Pricing Program limits the cost of covered outpatient drugs for safety-net providers. The ACA expands the definition of qualifying entities to include children's hospitals, free-standing cancer centers, critical access hospitals, sole community hospitals, and rural referral centers.

Addressing Language and Cultural Barriers

Several provisions in the ACA change the way that plans will communicate with their members by requiring plain language and increasing plans' cultural competence.

Uniform Plan Reference Documents

The ACA requires HHS to develop standards for use by health insurers regarding the summary of benefits and coverage explanation documents. HHS also must create a glossary, with standard definitions of terms used in health insurance coverage. These references must be "culturally and linguistically appropriate" as well as use "terminology understandable by the average plan enrollee."[24]

Exchange Activities to Reduce Disparities

HHS must consult with stakeholders and experts in healthcare quality to develop guidelines for state exchanges concerning, among other matters, the implementation of activities to reduce health and healthcare disparities, including through the use of language services, community outreach, and cultural competency trainings.

In April 2011, Governor Martin O'Malley signed exchange-enabling legislation into law. Since that time, Maryland's Health Benefit Exchange Board—along with the Health Care Reform Coordinating Council—has convened public meetings and workgroups with stakeholders in order to create an exchange that recognizes the unique characteristics of potential enrollees. For instance, a workgroup focused on exchange education and outreach is studying how health reform may affect different individuals, as well as how these individuals may participate in the implementation process. A critical question guiding this work: How will Maryland assure that efforts are effective and culturally and linguistically appropriate?[25]

Model Cultural Competence Curricula

The ACA creates grants to develop, evaluate, and disseminate research, demonstration projects, and model curricula for use in health professions schools and continuing education programs. Activities funded under these grants may include cultural competency, prevention, public health proficiency, health equity, and working with individuals with disabilities training.

HISTORY

A Brief History of Cultural Competence in the U.S. Healthcare System—the CLAS Standards

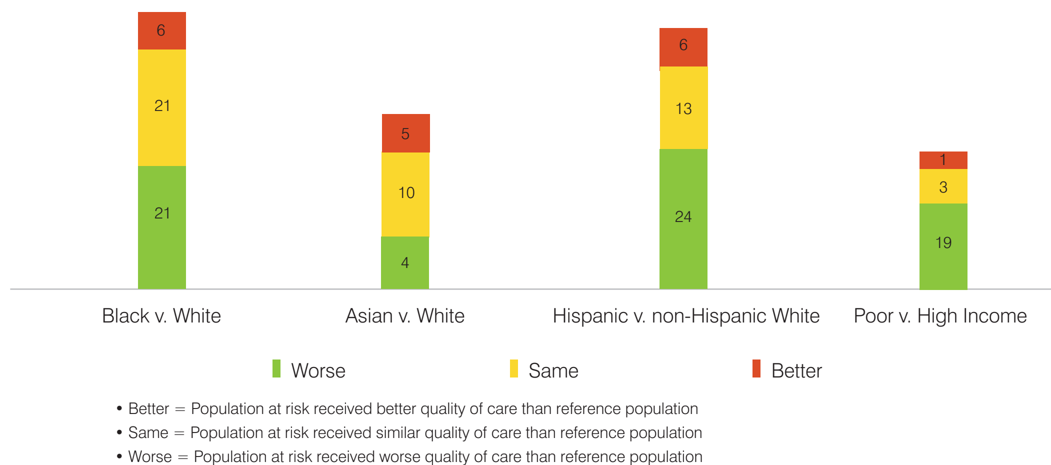
In 2001, HHS's Office of Minority Health published the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). The CLAS Standards offer a framework for the entire healthcare community to most effectively serve the nation's growing diversity. The CLAS Standards are a set of mandates, guidelines, and recommendations that present required and suggested practices related to culturally and linguistically appropriate health services. The CLAS Standards also include guidance on how to advance quality care in three areas: Culturally Competent Care, Language Access Services, and Organizational Supports.

Source: Department of Health and Human Services. (2011). "Think Cultural Health." Office of Minority Health. https://www.thinkculturalhealth.hhs.gov/Content/clas.asp.

The ACA Encourages Quality Measures and Adherence to Guidelines

The National Healthcare Disparities Report assesses quality of care through 179 measures each year. The 2010 report states that, of these quality measures, almost two-thirds showed improvement. However, the median rate of improvement was only 2.3 percent per year. On the other hand, fewer than 20 percent of disparities in quality of care experienced by blacks, American Indians and Alaska Natives, Hispanics, and poor people showed any improvement.[26] The relative distribution of core quality measures for populations at-risk of negative health outcomes compared to other populations illustrates that there is great room for improvement in quality of care. [Figure 37]

FIGURE 37: **Change in Core Quality Measures, by Race/Ethnicity, 2010**



Source: Agency for Healthcare Research and Quality (2011). The National Healthcare Quality & Disparities Reports. http://www.ahrq.gov/qual/qrdr10.htm

Development of Quality Measures and Implementation

Racial and ethnic minorities as well as populations with limited income experience poorer quality of care than the national average. The ACA aims to improve quality of care for all people through increased efforts to measure quality, to fund research on quality care, as well as to develop and enforce a national strategy to improve quality.

National Strategy to Improve Healthcare Quality for People with Chronic Conditions

The ACA requires HHS to establish and update annually, a national strategy to improve the delivery of healthcare services, patient health outcomes, and population health through a transparent and collaborative process. The strategy must aim to improve health; identify areas with potential for rapid improvement in quality; and address gaps in quality, efficiency, and comparative effectiveness information, among other requirements.

Interagency Working Group on Healthcare Quality

A new entity, the Interagency Group on Healthcare Quality, is created to improve collaboration between federal agencies and minimize overlap of healthcare efforts in carrying out the National Strategy to Improve Healthcare Quality.

Quality Measure Development

The ACA authorizes funding for grants to entities to develop, improve, and evaluate quality measures. Special consideration will be given to entities focused on measures related to equity of health services and improving health disparities in specific geographic areas.

In Maryland, a number of entities have already begun work in this realm. The Maryland Health Quality and Cost Council Disparities Workgroup, in conjunction with the University of Maryland School of Medicine, is charged with developing recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in the healthcare system. In September 2011, the Workgroup released draft recommendations to the overall Council: One of these recommendations was that the state's Health Services Cost Review Commission expand the scope of existing reimbursement incentives for quality. Specifically, the Workgroup calls on the Commission's current and future quality incentives to promote equity and reduce disparities.

Quality Improvement Technical Assistance

The ACA created new grants to entities to provide technical support to institutions that deliver healthcare and healthcare providers, including providers of services and suppliers for which there are disparities in care among subgroups of patients, rural and urban providers of services and suppliers, and providers of services and suppliers with poor performance scores.

Patient-Centered Outcomes Research Institute

A new private, non-profit entity, the Patient-Centered Outcomes Research Institute, is established to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. The law establishes specific research priorities for the Institute, including research on practice variations and health disparities in terms of delivery and outcomes of care.

Reporting Requirements

The ACA requires HHS to increase the availability and quality of data on health disparities and to improve efforts to pool government resources and expertise. New data collection requirements will result in more consistent methods for collecting and analyzing data on disparities.

Health Disparities Data Collection and Analysis

HHS must ensure that all federally conducted or supported healthcare or public health programs, activities, and surveys collect and report data on race, ethnicity, sex, primary language, and disability status, and other demographic data regarding health disparities. The agency must analyze all collected data to deter and monitor trends in health disparities. All data elements collected for racial and ethnic minority groups must also be collected for underserved rural and frontier populations.

Offices of Minority Health

The ACA establishes Offices of Minority Health at the CDC, HRSA, SAMHSA, AHRQ, FDA, and CMS. These offices are required to monitor health, healthcare trends, and quality of care among minorities as well as to evaluate the success of minority health programs and initiatives.

The ACA Promotes Appropriate Care

The ACA explores a variety of methods to improve the type of care that Americans receive. In addition to increasing access to coverage and improving access to healthcare services, it is also critical that people receive the care that is right for them. The law's efforts to promote appropriate care include increasing authorization and funding for health services provided in the community as well as renewing emphasis on prevention services.

Care in Communities

The ACA aims to reduce disparities in health by increasing the availability and effectiveness of community-based healthcare programs and services. Several specific programs will aim directly at increasing the accessibility of health services in communities at risk of disparities.

Maternal, Infant, and Early Childhood Home Visiting Programs

The ACA improves and strengthens the maternal and child home visiting programs for at-risk communities through identification and delivery of comprehensive services to improve outcomes for families who reside in at-risk communities. Communities with higher rates of premature births, low-birth weight infants, infant mortality, poverty, crime, domestic violence, substance abuse, unemployment, high-school dropouts, or child maltreatment are considered at-risk.

Community Health Teams in Medicaid

New Community Health Teams are established to deliver culturally and linguistically appropriate services in primary care and chronic disease management as a component of Medicaid's new focus on the patient-centered medical home.

Community Transformation Grants

The ACA creates grants to be awarded through the CDC to state and local governmental agencies and community-based organizations to implement, evaluate, and disseminate evidence-based community preventive health activities. Activities funded under these grants will aim to address health disparities, among other priority areas.

Community Health Workforce Grants

The ACA creates grants to be awarded through the CDC to organizations that promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers, sometimes known as "promotoras."

Prevention

The ACA places strong emphasis on the role that preventive care and prevention activities have in improved health and healthcare. New funding is available to support general prevention programs across the country as well as specific activities within Medicaid.

Increased Access to Preventive Services

The ACA included a number of provisions that seek to increase access to important preventive services by requiring private and public payers and Medicare to expand coverage and reduce financial barriers for four groups of preventive services:

1. Preventive services rated A or B by the U.S. Preventive Services Task Force (USPSTF).[27]
2. Immunizations and vaccines that have received a recommendation from the Advisory Committee on Immunization Practices.[28]
3. Preventive care and screenings recommended by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents.
4. Additional preventive care and screenings recommended by HRSA for women and not evaluated by USPSTF.

Prevention and Public Health Fund

New funding is appropriated for a Prevention and Public Health Fund to support programs that improve health and help restrain the rate of growth in healthcare costs. Eligible programs include the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits program, and the Immunization Program.

Incentives for Prevention of Chronic Diseases in Medicaid

New grants are available to states for certain healthy lifestyle programs under Medicaid. Eligible programs must be implemented for at least three years and provide incentives to Medicaid beneficiaries to participate in comprehensive evidence-based healthy lifestyle programs and meet certain healthy behaviors targets.

Implementation of Health Equity Provisions of the ACA

The ACA includes many provisions that directly aim to increase health equity. Others will have more of an indirect influence to reduce health disparities. These indirect influencers are aimed at improving healthcare in general or increasing access to coverage or care for a range of people.

Additionally, many provisions in the ACA are funded through discretionary funds that must be appropriated each year by Congress. The federal budgets established through the Congressional process over the coming years will determine levels of funding that would be used to implement so many of these programs and projects. With the recent budget stalemates, the future of some of these programs remains unclear.

Additional uncertainties lie in how states will implement certain aspects of healthcare reform. Much flexibility is given to the states in how they design and implement health insurance exchanges. States have the opportunity to create markets through which people will be able to purchase health insurance coverage. Ideally, these markets will also be fair, transparent, and easy to navigate. They also will have navigators to offer culturally and linguistically appropriate assistance to connect people to health insurance coverage that works for them. State budgets are stretched and many states have recently taken steps to creatively manage their Medicaid expenses. As states implement the health reform programs under their jurisdiction, they will have to negotiate the balance of cost and effective solutions.

The cost of health disparities due to increased healthcare expenses and premature death is steep. The Joint Center for Political and Economic Studies released a study examining this topic. The report's main finding is that health disparities cost the nation $1.24 trillion between 2003 and 2006.[29] At the same time, the proportion of minorities in the U.S. population is expected to continue to grow. Therefore, states will play a large role in ensuring that health disparities are addressed as healthcare reform is implemented nationwide.

Conclusions

The Center on Health Disparities has identified three priority action areas that will guide their reform activities in the coming years—data collection and reporting, National Strategy for Quality Improvement in Healthcare, and support of patient-centered medical homes. In each of these categories, the Center will build upon and expand current practices to more actively engage in areas specifically identified and promoted by the ACA.

In data collection and reporting, the Center will expand our work on the County Hospitals Health Equity Initiative to increase the availability and accuracy of local data to inform stakeholders about community issues. The Center plans to more widely disseminate training on data collection techniques for entities to gather accurate and appropriate data, which can be used to improve quality of care.

The National Strategy for Quality Improvement in Healthcare defines aims and priorities informed by dialogue with stakeholders nationwide, but it also clearly recognizes that healthcare is local. The Center developed the Adventist HealthCare Equity Report to increase awareness and utilization of demographics, quality, and health outcomes data to inform and guide quality efforts at our hospitals. Based on disparities identified in the Report, Adventist HealthCare hospitals can develop targeted interventions to improve quality by addressing issues among residents in the communities they serve.

The ACA establishes many criteria for patient-centered medical homes (PCMHs) in Medicaid, including that these programs offer care that is patient-centered as well as linguistically and culturally appropriate. The Center has established processes to create and enhance linguistically and culturally appropriate services that can be used to support PCMHs in Medicaid. Through its work with the Qualified Bilingual Staff Program, the Center has dramatically improved linguistic access for a number of non-English speaking patients by certifying bilingual staff on interpreting skills, which could enhance the PCMH's ability to provide appropriate care. The Center also has broad experience increasing the cultural competence of care. Specifically, the Center offers training on cultural competence for providers and support staff as well as diversity training. These programs offer not only a model for PCMHs as these models are implemented, but also a validated best practice for other centers as they implement PCMHs.

Chapter Three

Tremendous work has occurred on the local, state, and national levels to address health disparities and improve the provision of care to racial and ethnic minorities. Although much remains to be done, we are hopeful that strides will continue to be made so that all people can lead healthy lives.

THIS REPORT DESCRIBES THE HEALTH STATUS OF RACIAL AND ETHNIC MINORITY COMMUNITIES IN THE tri-county area across three key health topics: maternal and infant health, heart disease and stroke, and cancer. In 2007, we identified a specific set of initiatives to bring us closer to the elimination of health disparities across all communities. Below, we highlight the activities the Center has undertaken to achieve the goals set forth by these three recommendations.

1. Expand outreach and services for needs of racial and ethnic minorities.

Four years ago, we noted that additional resources should be devoted to the efforts of healthcare providers, health departments, state agencies, and community organizations. These entities carry out important work related to raising awareness of health issues specific to minority communities, while also providing screening programs, support services, and other interventions to these populations. As a result, Adventist HealthCare and the Center have worked closely with a number of local hospitals and health clinics, as well as county health departments, to ensure that they have the resources necessary to continue offering services that improve the health of racial and ethnic minorities. Some of these partners include the Maryland Hospital Association, Kaiser Permanente, Sinai Hospital of Baltimore, University of Maryland College Park School of Public Health, Montgomery County Department of Health and Human Services, and the Primary Care Coalition of Montgomery County.

More specifically, Adventist HealthCare and the Center have worked closely with two entities to provide services directly to patients in the community. First, for over 40 years, Adventist HealthCare has partnered with Mobile Medical Care (MobileMed) to operate three mobile healthcare vehicles equipped with laboratory and diagnostic services at Washington Adventist Hospital and Shady Grove Adventist Hospital. MobileMed provides primary and preventive healthcare to the uninsured, low income, working poor, and homeless in Montgomery County. One of the guiding principles of MobileMed is to acknowledge the unique character of the communities it serves by being responsive to local needs. Specific communities addressed by MobileMed include Montgomery County's African American, Asian, Ethiopian, Haitian, Hispanic, Middle Eastern and West African populations. The MobileMed vans also spend time at CASA de Maryland, a community center for immigrants.

Similarly, through Washington Adventist Hospital's Vision for Expanded Access, Adventist HealthCare developed a partnership with Mary's Center for Maternal and Child Care to provide healthcare services to families in the Washington, DC area. The Center aims to offer healthcare, education, and social services that are "sensitive to culture and family." In 2008, the partnership opened a primary care clinic in the Long Branch area of Montgomery County, and in 2009, prenatal care services were added to the clinic's offerings. In fiscal year 2011, 637 deliveries took place at this location. In addition, earlier this year, Washington Adventist Hospital and Mary's Center announced that they would be opening a second clinic on the Hospital's Takoma Park campus. Adventist HealthCare also teamed up with the Montgomery County Department of Health and Human Services' Maternal Partnership Program in 2006 to provide obstetric and gynecologic services for uninsured women in the county. Through this initiative, Adventist HealthCare was able to serve 1,200 women in two clinics in 2010. The project continues in 2011.

ANNUAL PROGRESS REPORTS AND CONFERENCES

The Center on Health Disparities aims to enhance knowledge, dissemination, and implementation of best practices key to eliminating health and healthcare disparities. Each year since 2007, the Center has developed and distributed annual progress reports in conjunction with our yearly health disparities conferences. The conferences are a means of assembling community stakeholders and sharing new research and best practices in community interventions to address and eliminate health disparities.

Past report topics have included Social Determinants of Health, Eliminating Disparities through Patient Centered Quality Care, Leveraging Research and Policy to Eliminate Health Disparities, and Eliminating Health Disparities in Frederick, Montgomery and Prince George's Counties in Maryland. Each year, these reports explore new research and new perspectives on the incidence and prevalence of disparities. They also discuss effective strategies to promote health equity and improve quality.

In addition to direct health services, the Center works closely with Adventist HealthCare to ensure that hospital sponsorships and investments are directed to organizations aimed at reducing health disparities. These investments are made through the Community Partnership Fund, which invests in projects and initiatives that work to increase access for the underserved, disseminate care improvements, address social determinants of health, and influence public policy. Funded projects include initiatives that improve culturally competent care and linguistic services, promote health and wellness in the areas of cancer and cardiovascular services, foster collaborations, and promote healthcare careers and policy advocacy.

The Center also has taken advantage of various communication channels, including social media, to promote the important work done by the Center and our partners to reduce health disparities. Our website (http://www.adventisthealthcare.com/health-disparities/) informs the general public about our health disparities research agenda, as well as the education and health services we provide to our community. We also send a monthly Health Disparities e-newsletter to a distribution list of approximately 1,000 subscribing members. Similarly, about 7,000 Adventist HealthCare employees receive our internal bi-monthly publication, which includes a "Spotlight on Health Equity." In addition, the Center recently created a Facebook page that keeps our 176 "fans" abreast of our latest news and activities.

2. Pursue coordinated research into the underlying causes of health disparities, the efficacy of various health initiatives, and the appropriate knowledge diffusion strategies into local communities and caregivers.

While differences in certain health disparities have narrowed (e.g., lung cancer incidence and mortality, receipt of mammograms) over the last five years, racial and ethnic minorities still suffer and die from a number of health conditions more frequently than their non-minority counterparts. As we stated in 2007, providers, researchers and policy makers need more data to explore the causes of disparities, as well as the impact of interventions aimed at reducing these disparities. At that time, a coordinated research agenda on health disparities began to take hold across the state, thanks to efforts of the Maryland Department of Minority Health and various county health departments. For example, Montgomery County's Health Montgomery community health improvement process (http://www.healthymontgomery.org/)—a community-based effort to improve the health and well-being of Montgomery County—provides

a concentrated source of population-based data and information about community health and the social and environmental determinants of health. Since the publication of the 2007 report, the Center has been involved in and aware of additional activity at the local, state, and national levels to improve the collection and racial and ethnic data across the healthcare system.

The Montgomery County Hospital Care Equity Initiative (MCHCEI), a pilot program of the Engelberg Center for Health Care Reform at the Brookings Institution in collaboration with Adventist HealthCare and other Montgomery County hospitals, is a prime example of this coordinated effort on the county level. Local hospitals are collecting specific data elements in order to build their capacity for examining local health disparities, measuring healthcare equity, and enhancing healthcare quality improvement efforts. As part of this initiative, patient registration and other staff of Adventist HealthCare are trained to ask all patients about their race, ethnicity, language preference, and other personal information in order to improve the accuracy of data collection. They are also trained to understand why it is important to collect such information and how it will be used. To aggregate data in the simplest way possible, the MCHCEI selected a set of quality measures that were already required for hospitals to report to the Maryland Health Services Cost Review Commission. The measures are also part of the Joint Commission's list of CORE National Hospital Quality Measures. In addition, the hospitals are required by the state to gather race and ethnicity data for all patients, and the program identified a level of granularity in the race and ethnicity identifiers that could be standardized across the hospitals. Although the quality data were not stratified by race or ethnicity, the hospitals needed only to crosswalk their patient demographic data with the quality measures.[30]

On the state level, the University of Maryland's (UMD) School of Public Health received a grant from NIH's National Heart, Lung, and Blood Institute to improve Maryland's approach to cultural competency in healthcare. UMD worked with national-level entities, such as the American Association of Medical Colleges, to develop standards for defining race, ethnicity, culture and cultural competence, which has significantly improved researchers' abilities to collect and query electronic data. As a result, it is becoming easier for various entities to ensure that their research on health disparities is consistent and coordinated.

Even prior to the new ACA-required reporting requirements, Adventist HealthCare has utilized a data collection system to collect race, ethnicity, age, language, and gender information from its patients.

The ACA has created new methods of addressing health disparities through its provisions to improve health insurance coverage, quality of care, and cost. While most of these changes are aimed broadly across the population, some of these new requirements address gaps in the healthcare system for specific populations. Now, due to the ACA, HHS must ensure that all federally conducted or supported healthcare or public health programs, activities, and surveys collect, report, and analyze data on race, ethnicity, sex, primary language, and disability status, and other demographic data regarding health disparities in order to identify where these disparities exist. HHS also must analyze all collected data in order to monitor, address, and deter trends in health disparities.

In recent years, the Center has committed resources to increasing the details collected about individuals served within the Adventist HealthCare system. Through a new data collection system, Adventist HealthCare hospitals now collect race, ethnicity, and language preference from their patients. While many healthcare systems collect these data, the ACA reporting requirements will facilitate the next step of the process—analysis of the data to inform next steps for quality improvement.

3. Promote culturally and linguistically competent care and funding mechanisms to foster the exchange of best practices.

A major focus of the Center over the last four years has been to distribute best practices to healthcare providers. The Center has worked to disseminate innovative strategies for eliminating health disparities to community health organizations across the region. A number of these strategies have targeted providers and other healthcare workers, as these individuals greatly influence how patients think about and use health services.

One of the main ways the Center has fostered culturally and linguistically competent care is through our Cultural Competence Assessment. For the last three years, the Center has worked closely with Sinai Hospital in Baltimore, guided by principles adapted from a Health Resources and Services Administration (HRSA) Cultural Competence Assessment. From these guidelines, the Center created a tool for Sinai Hospital leadership to assess the overall cultural competency of the organization; participants of the assessment rated Sinai on various factors, such as availability and accessibility of service, and general atmosphere. The results of the survey provided a foundation for understanding how the hospital meets patient needs in a culturally competent way. In addition to the survey assessment, the Center also spent time presenting at Sinai Hospital's grand rounds and executive meetings, conducted interviews and focus groups, and observed the facility in action to truly assess how a diverse population of patients is served. Following this full assessment, the Center worked with Sinai Hospital's leadership to create a strategic plan for the facility that would improve various performance measures based on HRSA's best practices.

About 1,000 individuals subscribe to the Center's monthly Health Disparities e-newsletter.

2011 HEALTH EQUITY REPORT

As part of our mission, the Center helps all Adventist HealthCare entities effectively respond to the increasing cultural diversity in our communities. This year, the Center has published our first Health Equity Report; this report examines the diversity of patients in the Adventist system as well as our progress on the Center's goal of reducing health disparities and promoting health equity. The Report shows no difference in most quality measures for heart failure, acute myocardial infarction, pneumonia, and surgical care by race or ethnicity; however, there were discrepancies in rates of receipt of certain vaccinations, as well as discontinuance of prophylactic antibiotic after surgery.

The Center has also trained employees of 11 different organizations in Maryland and Virginia—including the Maryland Hospital Association and the Virginia Department of Behavioral Health and Development Services—through a Qualified Bilingual Staff (QBS) "Train the Trainer" program. The QBS program, which was modeled after a Kaiser Permanente initiative, has been in place since 2007 and was designed to prepare participants to facilitate the QBS curriculum in their own facilities. As of September 2011, approximately 350 providers and staff have participated in the three-day (24 hours total) training program that enables them to heighten awareness of health beliefs, practices, and health-seeking behaviors that differ from traditional Western medical practice, while also improving their ability to provide linguistically sensitive care. Currently, the QBS program trains providers in 14 languages, including Spanish, Russian, French, Japanese, and Arabic.

Finally, the Center has used the Joint Commission's roadmap for "Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care" as the basis for an interactive tool. The roadmap is intended to help organizations better understand individual patients' needs and to provide guidance on how to address those needs. The checklist focuses on the continuum of care (admission, assessment, treatment, end-of-life care, and discharge and treatment) and how ready an organization is to address each point on the continuum based on five elements:

- Leadership
- Data collection and use
- Workforce
- Care, treatment, and services
- Patient, family, and community engagement

This tool is available for staff to track how well Adventist HealthCare facilities are doing and whether they are compliant with quality standards.

Overall, the last four years have been extremely busy for the Center and our partners in the community. A great deal of work has been done on the local, state, and national levels to address health disparities and improve the provision of care to racial and ethnic minorities. Although much work remains to be done, we are hopeful that strides will continue to be made so that all people can lead healthy lives.

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The Reginald S. Lourie Center for Infants and Young Children

Adventist HealthCare Center on Health Disparities
1801 Research Boulevard · Suite 200 · Rockville, MD 20850 · 301-315-3677
http://www.adventisthealthcare.com/AHC/health-disparities/